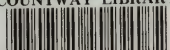


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ECTOPIC GESTATION.*

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The question of diagnosis and treatment of ectopic gestation opens up a wide field and it is not my intention to consider either the early symptoms or treatment but in a brief way to take up the symptoms and treatment in those cases that have by some miraculous means passed the many dangers to both the mother and foetus and reached the latter months of gestation before the condition is recognized. There is considerable doubt as to whether a primary implantation of the ovum can take place upon the peritoneal surface and thus give rise to abdominal pregnancy. While it is very common for authors on this subject to divide extra-uterine pregnancies into ovarian, abdominal and tuba varieties, yet there are very good reasons for believing that nearly all ectopic gestations are primarily tubal. Rupture between the folds of the broad ligament takes place in a few cases, through that portion of the tube wall, which is not covered with peritoneum and in such cases the ovum escapes downward into the space which is situated between the folds and the peritoneal covering of the broad ligament. This is considered the most favorable termination of a tubal pregnancy in the early months and usually results in the death of the ovum and the formation of a broad ligament haematoma. More rarely the pregnancy may

*Read before the Kansas Medical Society at its meeting in Topeka, May 7, 8, 9., 1906.

go on to a term in this situation and in such a case it is evident that the placenta being attached to the unruptured portion of the tube wall will lie at the superior portion of the gestation sac. In such cases the pregnancy is entirely outside of the peritoneal cavity and is sometimes spoken of as a broad ligament or extra peritoneal pregnancy. And again occasionally where the rupture takes place into the peritoneal cavity the mother and the ovum survive the first hemorrhage and if the placenta be not entirely separated from its attachments to the tube wall, an abdominal pregnancy results. In such a case the ordinary symptoms of pregnancy will continue but in all probability with an abnormal amount of pain and pelvic tenderness. In these cases in which the foetus and mother have survived the damage done at the time of primary rupture and the foetus continues to develop in the gestation sac or abdominal cavity the diagnosis is not usually made until late in the case because attention is not directed to the fact of early rupture and it often is not until false labor sets in that the physician's suspicion is aroused as to the fact of the child not being in the uterine cavity. If careful examination be made, however, the recognition of the condition should offer little difficulty, as the child is found to be more easily palpable than in the normal condition and its movements give the mother more pain. By bimanual examination the uterus is found to be nearly normal in size and pushed entirely out of its normal position. If a careful history of the case be taken from the beginning there will usually be found to have been some interruption or irregularity in the menstrual period and decided symptoms of rupture attended by shock along between the second and fourth month. An ectopic gestation is analogous, says Dr. Werth, to a malignant tumor hence prompt action is demanded. It is impossible that the experience of any one surgeon is sufficient for him to dogmatically outline rules for guidance but from the combine experience of others I conclude that from the fourth to the seventh month, if an ectopic gestation be recognized we should immediately proceed to remove it. After the seventh month in the interest of the child we should wait until near term, and now comes the rub. The modern teaching is to operate before spurious labor sets in, believing that the danger from hemorrhage is not greater than the probabilities of infection with its almost fatal ending. Sutton's statistics are almost conclusive in sixteen laparatomies performed after the death of the foetus at about full term all of the mothers recover. In thirteen laparatomies performed while the child was alive, eight mothers died and only two children lived. For the ten years from 1889 to 1898 inclusive, Dr. Harris collected forty cases of operations for ectopic gestation where the child was viable. Of these, twenty-seven mothers recovered.

We know that while procrastinating in the interest of the child, fatal hemorrhage may occur, and there is the ever present danger of infection. Dr. Pozzi thus disposes of the question as to the propriety of waiting for spurious labor and the death of the child, says, "One may obtain no advantage from delaying which necessarily sacrifices the life of the child and expose the mother to fresh complications. Here as in nearly all problems of abdominal surgery, the theoretical objections of the timid disappear before the brilliant results of courageous action combined with skill." It therefore appears that after the seventh month the child known to be alive we should watchfully await to within 2 or 3 weeks of full term then proceed with the undertaking. The ideal consummation of which consists in the removal of the foetus, placenta and gestation sac. The first step is the removal of the child and this as a rule should be done by abdominal section. It will matter little, whether median or lateral incision be employed. One may have advantage over the other in case the location of the child and probable attachment of the placenta can be defined. But the really dangerous part of the procedure is reached when it comes to dealing with the placenta and gestation sac and the judgment of the surgeon is here taxed to the fullest extent and while in some cases depending upon the attachments it may be safe to attempt the removal, yet in other cases it will be wiser to suture the membranes to the abdominal incision providing drainage and trust to nature to get rid of the debris by disintegration or remove it later by a second operation when the placental circulation has been obliterated. Just what course to pursue is a matter that as a rule must be determined by the surgeon after delivery of the foetus and we should remember that the deliberate attempt to remove the placenta is apt to result in dangerous hemorrhage and hemorrhage that may perhaps be uncontrollable. Hence in many cases it will be better not to attempt the removal of the placenta for two or three weeks and in other cases where it is decided to remove the placenta it possibly may be better to do a hysterectomy, by the Porrs operation.

Case 1.

Was called in consultation with Dr. Unthank on March 2nd, 1905, to see Mrs. R.—colored, age 28 years, residence Kansas City, Kansas, married eight years, one child six years old. She was complaining of great pain in lower abdomen, more severe in lower part of back. She had slight bloody flow from vagina, which had been present for one week. She gave the following history:

For the past seven months had been feeling badly and in November she had consulted Dr. Unthank of Kansas City, Mo., at which time she was in doubt as to whether she was pregnant or not. She had suffered for several weeks at the time with nausea and vomiting, especially in the morning; also with considerable pain in pelvic region. The doctor prescribed for her giving her a sedative and suppository of boro glyceride.

She had come to the doctor's office on the street car and started back home taking the street cars. On the way home she was attacked with very severe pain in abdominal regions and became so faint that she was removed from the car and carried to her mother's house, a short distance from the car line. Dr. Unthank was called to see her and calling another physician she was anaesthetized, cervix was dilated and uterine cavity curetted but he found nothing in the uterus except clotted blood. She remained at her mother's home one week before she was able to be removed to her own home. After this she gradually regained her strength and called at the doctor's office several times complaining of a heavy feeling in the pelvic region and of considerable pain and tenderness. At the time I examined her on March the 2nd she was confined to her bed and had been for past two weeks on account of the severe pain and great soreness. She had a bloody discharge from the vagina which was not very profuse and had been present for one week. Examination of her vagina revealed a mass filling the pelvis could be made out distinctly to be a foetus as the head was pressing down so that it rested on the perineum. The uterus somewhat enlarged was pressing upward and of the left. Os uteri was soft and somewhat dilated and was very high and behind the symphysis pubis. Diagnosis of extra uterine pregnancy was made and operation advised. She was removed the next day to the Douglas Hospital where I operated on her on March the 4th at 2:40 p. m. The abdomen was opened through a median incision. The foetus seemed to be only partially within the folds of the broad ligament but everything about it was adherent and the foetus enclosed in membranous sac containing considerable amount of amniotic fluid. Foetus was removed alive and without much hemorrhage, seemed to be well developed and must have been seven months or more. The child lived about fourteen hours and I think died from getting chilled, the weather being quite cold at the time. The cord was tied and attempt to remove the placenta brought forth quite a severe hemorrhage. The placenta attachment seemed to be mainly to the right broad ligament and omentum. The omental attachment was ligated and cut away, the right broad ligament and ovary also, the placenta membranes being removed with the loss of only a moderate amount of blood. The patient took the anaesthetic very badly all through the operation, in fact ceased breathing twice and had to have artificial respiration for some time to resuscitate her. The operation lasted about two hours and she went to her bed with considerable shock. Her pulse being 140 and respiration 42, normal salt solution was administered per rectum and under the breast during the night. The next morning the temperature was 100, pulse 130 and respiration 30 but her heart gradually failed during the day and she died thirty-six hours after the operation of what I take to be shock, though the temperature reached 102 on the evening following the operation and she vomited frequently during the day. The cavity from which placenta was removed was packed with sterile gauze brought to the lower angle of the wound the major portion of the wound being closed. From this gauze there was very profuse oozing of blood up to the time of death and probably had much to do with continued shock and the death of the patient.

Case 2.

Mrs. M. V.—aged 35 years, the mother of four children the youngest five years of age. Had one miscarriage four years ago. Father and mother both living and in good health. One sister died at the age of twenty-four years from pulmonary tuberculosis. Her health has not been good for the past four years but she has been especially poor for the past eight months, complaining of great abdominal pain and constant tenderness over abdomen, for past three weeks has been confined to bed suffering greatly with pain

in lower abdomen, during past week had some elevation of temperature and for last week has had slight bloody flow.

Early history: Has menstrated regularly until last June. Menstrating about May the 17th last, failed to menstrate in June and twenty days after expected menstration flow appeared but was not natural. Flow came in gushes and she suffered considerable pain. Soon after this she noticed some enlargement of the abdomen and had a craving appetite, such as she had with former pregnancies. The flow at the time continued for twenty days at which time flow ceased, and she did not flow again until in August when she was attacked with severe pain in lower abdomen, and flow again appeared. Pain extended over entire abdomen and she vomited freely and frequently more or less for ten days, during which time bowels would not move and she was treated for obstruction of the bowels. After bowel movement was obtained she gradually improved but abdominal tenderness continued and the enlargement of the abdomen persisted until about January 12th; pain in abdomen became more severe and flow re-appeared in few days. About January 25th I was called in consultation with Drs. Fairbanks and Jones. After obtaining above history I made vaginal examination and could feel a boggy mass filling the pelvis and displacing the uterus upward and to the left. Could make out the head of the foetus and the os uteri was soft and slightly dilated and there was slight bloody flow. Her pulse was weak and rapid, 115, slight elevation of the temperature, unable to eat anything and continuously in great pain in lower abdomen, where there was a great tenderness. I was unable to detect any foetal movements or hear the foetal heart-sounds. The diagnosis of extra uterine pregnancy was made and operation urged. She was admitted to St. Margaret's Hospital, January 26th, 1906, and operation performed on the 27th. The abdomen was opened by a median incision between the umbilicus and symphysis pubis, on separating the adherent coils of intestines the sac containing the foetus was opened and foetus delivered. The cuticle slipped from the body and extremities of the foetus and I judge it must have been dead several days. After dividing the cord the membranes and placenta were removed, the principal attachment of the placenta was to the right broad ligament fundus and posterior surface of the uterus but was removed without the loss of a great deal of blood, but it was thought best to tie off and remove the broad ligament tube and ovary with the placenta as the hemorrhage was profuse in trying to separate it. After removing the membranes and placenta the cavity was packed with a slight gauze pack and wound closed except at point where gauze packing came out. The shock following the operation was only moderate but the oozing was quite profuse for thirty-six hours. There was a slight infection of the wound and the cavity had been packed with gauze but was never very troublesome and our patient left the hospital four weeks after the operation with wound nearly healed and same was entirely healed on the first of March.

She menstrated in March beginning on the 19th and lasting six days, flow was quite free and did not suffer with much pain. Flow reappeared again in two weeks, lasting three days. From this time she felt fairly well, gained flesh and strength, but suffered from nausea, especially in the morning. April 25th began to have pain in left inguinal region, and consulted me at my office on April 27th. Vaginal examinations showed mass to left and posterior to uterus pushing same upward and to right; to the touch mass seemed to be fluid. She also had intermittent flow from vagina, with some clots. Temperature was normal and wound seemed to be healed firmly; no tenderness on right side. I was uncertain as to just what the condition was, and advised her to go back to the hospital for another operation. There was a suspicion in my mind of second tubal pregnancy on left side, but found that the ovary was cystic containing a cyst as large as a medium sized orange also two or three smaller cysts

around the ovary. These were all opened up and cyst walls partly removed, and wound closed with wick drain. This brings up the question: "Should we leave the ovary and tube on the unaffected side and take the chances of further trouble such as this, or perhaps another tubal pregnancy?" It is quite evident that this lady would have been better off if both tubes and ovaries had been removed at time of first operation, though she has had no trouble from second operation which was done May 3, 1906.

DISCUSSION.

DR. STEVENS: My experience with ectopic pregnancy being limited, I can do little more than thank Dr. Gray for his very able paper. The subject of ectopic pregnancy concerns us deeply. A precious life often depends upon an early diagnosis, and upon intelligent, prompt treatment.

I have seen three cases of ectopic pregnancy; one of them a lady who had exophthalmic goitre until the rupture of tubal pregnancy at about two months. I concluded that the goitre with its exophthalmic symptoms were secondary to tubal pregnancy.

Another case I saw after the rupture of about eight weeks tubal pregnancy. There was considerable hemorrhage, continued on until with the shock the woman died. I had an opportunity to operate at that time, but I was too timid, believing that the shock and hemorrhage would prove fatal, and I thought of the effect it would have upon my reputation, and no operation was done. I have concluded since then that in like case I would think of nothing more than duty. I believe it was my duty then to operate and another case like that I should, where I had the opportunity and the consent of the friends.

I did operate once for an ectopic pregnancy accidentally. There was a patient brought to me and placed in the Caney Hospital. I knew her husband to have had gonorrhoea two years previous. While I had instructed that husband that for a year after he had become infected not to take chances of infecting his wife, I believed probably the woman was infected. She had defective tubes. Probably all the tubal pregnancies are due to infected or defective tubes. Perhaps gonorrhoea is the most frequent cause. The woman had a tumor showing in the cul-de-sac of Douglass. For three weeks she had suffered great pain. I concluded there was an abscess, and made an incision in the tumor. I removed about a six weeks' pregnancy, so I have operated once for ectopic pregnancy, but did it accidentally.

DR. GRAY: Mr. President, I don't know as there is anything more that I can add on the subject more than that of course I have seen and operated upon some considerable number of cases in the earlier months of ectopic gestation. The object of this paper was to bring before you the dangers, especially of the treatment where pregnancy has advanced to this stage. As I understand, every month the pregnancy advances, say after three months, the greater the danger from trying to remove the placenta. If you make an attempt to remove it you cannot back out; you have got to go ahead because you will probably not be able to control the hemorrhage already started. I would have brought a placenta up here, but I thought it was too far to carry it.

Of course, another point that enters into the treatment of these cases is, what regard should we have for the child's life? The possibility of these children living and amounting to anything after delivery is good. I was unable to trace any of these children beyond the second year. Of some fourteen cases delivered, only two of them lived beyond the second year. So that it seems that the life of the child is not deserving of very much consideration when you take into consideration the very great danger the mother has got to continue to go through in these months she has to be waiting for the child to be delivered.

THE PRESENT STATUS OF EXOPHTHALMIC GOITRE.

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In the medical writings of recent years there is no subject that has afforded a more promising field or occupied a more prominent place than that of Graves' disease. First reported in 1800 by Flajani, who gave a brief and inaccurate description of its main features, it was identified by Parry in 1825 who reported eight cases exhibiting the syndrome of tachycardia, struma and exophthalmos. The disease was further described by Graves in 1835 and independently by Basedow in 1840, who was the first to call attention to the tremor. While the four cardinal symptoms (of which any one may be absent with the exception of tachycardia) are the basis for diagnosis for this condition, from time to time new and more or less constant features have been added until at the present time, we must be prepared to recognize a wide variety of symptoms as connected with this morbid condition and the practitioner comes in contact with many types of the disease varying from the classic, to those of the greatest clinical complexity, in which all of the so-called cardinal symptoms with the possible exception of tachycardia, may be so masked and overshadowed by others that are not so generally associated with it as to be elicited only by the most careful and patient examination.

The various theories as to the exact pathogenesis of the disease that have been advanced from time to time, convey some idea of the difficulties sometimes encountered in its identification. Thus of the earlier writers, Graves considered it a disease of the heart, Taylor and Piorry assumed the symptoms as due to the compression of the cervical vessels and nerves. Bernard attributed the phenomenon to a disease of the cervical sympathetic, a view also held by Koben, while Charcot considered it a pure neurosis analogous to hysteria. At the present time the problem of etiology seems no nearer a solution than ten years ago.

The contention of Stein (*Wiener Med. Woch. Nov. 25-05*) that it is purely a thyroid degeneration is ably and energetically opposed by Gordon (*N. Y. and Phil. Med. Jour. Nov. 4-05*) who attempts to show that primary involvement of the sympathetic nerves is always in evidence citing several personal cases to prove the grounds of his assumption. He maintains that the results of operation on the sympathetic ganglia give better comparative results than partial thyroid ectomy, though this conclusion is at variance with the statistical reports of Hartley and Balescescu as will be shown later.

It has been conclusively shown by Exner and by Edmunds that

lesions of the sympathetic nerves may produce either hyper activity or atrophy of the gland. As pointed out by Sheldon (Indications for operative treatment) however this neither explains nor settles the question of the primary and most important lesions of the disease.

The two principal theories at the present time are first, that its origin is bulbar, supported by the combination of vasomotor, thermic, cardiac and secretory disturbances and by its occasional association with facial paralysis, ophthalmoplegia, auditory and trifacial nerve disturbances and supported by the experiments of Filehne and Dordufi who succeeded by producing experimental lesions of the restiform bodies in eliciting all of the cardinal symptoms of the disease. By far the greater majority however, are inclined to view the condition as due to hyperthyroidation, a systemic autotoxemia from over activity or perverted function of the thyroid itself.

A review of the arguments for and against the theories advanced as to the primary pathogenesis would be profitless, as the intention of this paper is to deal more with the clinical than the pathological aspects of the disease, and more especially with the methods at our command for the relief of the condition. Though a lengthy discussion of the etiology would be superfluous, there are many significant points that challenge our attention. Occurring more frequently in women than in men in the variously estimated proportion of 46 to 1 (Buchan) to 4 to 1 (Thompson), it is essentially confined to the reproductive period and is rarely encountered before the age of puberty or after the menopause though Thompson records several cases occurring in his practice at the climacteric. The recent study of 32 cases by Dock (American Medicine Feb. 24-06) is confirmative of a very high sex ratio, there being 29 females and 3 males in this series, extremes of age being 18 to 55, the greatest number occurring between the 21st and 25th year.

Batchelder (British Journal of Children's Diseases, 1905, No. 2), reports a case following whooping cough in a child three and one half years old, death occurring at the age of 6 years. As exophthalmos has been known to occur in pertussis independently of thyroid involvement and as tachycardia has been known to be present in thymic hyperplasia and as the pathology of rapidly developing structures lacks the exactness and precision of fully developed organs, a reasonable doubt may be entertained as to the exactness of his diagnosis. The same may also be said of a case of congenital (?) exophthalmic goitre reported by Burns (Canada Lancet, March 1905), the principal clinical symptom of which was cyanosis and dyspnoea, as there was nothing in the post-mortem findings to exclude death from purely mechanical causes. Stephenson's (British Journal of Children's Diseases, 1905, No. 2) occurring in a 12

year old boy is more authentic, while a case in a boy of 14 came under my personal notice in Mercy Hospital, Chicago, about three years ago.

The influence of neurotic heredity is in many instances apparent and the effect of emotional disturbances such as fright, grief, worry, mental strain, etc., as etiological, or at least contributing factors in its causation, emphasizes a certain analogy in this respect between this condition and paralysis agitans, and while the extreme degree of vasomotor irritability is highly suggestive of the profound disturbance of the sympathetic system, the constant changes in the secreting structure of the gland and its heightened vascularity are never wanting and furnish the strongest evidence of the over-activity of this structure. The pathological changes in the sympathetic system and spinal cord that were at one time thought to be a part of the pathology of this disease are shown to be inconstant, inconclusive and devoid of direct pathologic significance, and at the present time are thought to be more the result of the nutritional disturbance than of the disease proper, as the same type of degenerative process has been noted in pernicious anaemia^a in Addison's disease and other conditions marked by asthenia and emaciation. The persistence of the thymus and the occurrence of lymphatic hyperplasia, together with the increased vascularity of these structures, would tend to show an attempt of compensatory effort which might explain to some extent the tendency to collapse and the low vital resistance of this class of patients.

It is of the greatest importance to bear in mind the fact that we may have a primary and secondary, as well as an acute and chronic form of the disease, that the symptoms of hyperthyroidia may develop in any type of goitre and especially that its occurrence in a rapidly enlarging thyroid is to be considered equally as indicative of incipient malignancy as the development of a Morbus Basedowii. As a rule, the secondary form (malignancy excluded) affords a more favorable prognosis in all cases, but it is conceded that marked and rapidly progressive symptoms developing upon a preexisting goitre if uninfluenced by more conservative treatment should be subjected to early surgical measures as in these cases the symptoms appear rapidly progressive and obviously demand early relief, both because of the rapidity and progressive tendency of alarming symptoms and the possibility of malignancy.

Whether the symptoms occurring in connection with this disease are due to a special form of toxemia or autointoxication resulting from over-activity or perverted function of the thyroid or para thyroid and the consequent presence in the blood of certain unneutralized toxic secretions elaborated thereby, the specialization of the toxemic effect being exerted on the sympathetic system, as contended by Moebius, the primary

pathological lesion being in the thyroid itself, and it being solely responsible for the altered metabolic processes, or whether the trophic disturbance originating primarily in an irritated condition of the vasomotor system exciting stimulation of glandular activity by a constant hyperaemia as Ehrig maintains, is not so pertinent to us at the present time, as the ability to determine the existence of the malady and to wisely choose the most safe and speedy measures for its relief.

The course and progress of the disease being notoriously uncertain, it is impossible to say at its onset, especially if it be acute, what the subsequent course will be. While many of these cases terminate in spontaneous recovery after months or years, by far the greater majority exhibit a progressive tendency, and are characterized by periods of exacerbation and remission each attack tending to become more prolonged, the symptoms more marked, the interval of improvement shorter and the recovery from prostration slower. A thoroughly satisfactory method of treating this condition is not at present at our command. That all cases in their inception fall legitimately under the head of internal medicine, cannot be gainsaid, and it is only after the measures at the command of the internist have been exhausted without appreciable benefit, that these patients should become the object of surgical intervention. In this connection, however, a warning should be sounded against too great optimism on the part of the physician. He should bear in mind the general tendency of the disease toward temporary remissions, the obvious limitations of therapeutic treatment and should not prolong his treatment until the condition becomes so desperate and the vitality of the patient so depleted, that operative measures must of necessity be extremely hazardous. Hygienic methods of living, a high altitude and hydrotherapy are of unquestioned benefit in the majority of these cases while the limitations of drug treatment are marked and their employment purely symptomatic.

The use of thyroidectomized goat's milk as advanced by Lange or the dessicated curd in the form of Radogen gives promise of better results in the future, but the increased cardiac irritability resulting, demands the closest attention on the part of the attendant. The results of the serum treatment have not been sufficiently demonstrated to warrant a full discussion. The effects of the galvanic and faradic currents appear to be purely psychic.

Gorl (*Much. Med. Woch.* 130-3 No. 5), reports very satisfactory results from the use of the Roentgen ray, but the method is too uncertain to merit much dependence. As to the indication, time for, and method of surgical intervention, it may be briefly said that all cases excepting those of rapidly progressing or fulminant character, should have the

benefit of hygienic and medical treatment before operative measures are undertaken. In a discussion of the indication we might say in this respect that the type and general progress of the disease should be closely studied as those that show evidence of a rapidly progressing or fulminant course should have the benefit of early operative intervention. Cases in which the pulse reaches 130 to 140 should be operated if possible in the interval of remission when the pulse is 100 to 110, as operative measures undertaken when the pulse rate is high show a marked increase in mortality over those where the rate is comparatively low. The general physical condition of the patient, nutritive and excretory should be closely scrutinized as they are prone to be overlooked or at least given inadequate consideration in the absorbing study of the vascular and nervous phenomena. By no means is operation demanded or even justified in all cases of this disease, and those exhibiting a wide variation in the cardiac and nervous symptoms, those attended by continued and exhausting diarrheas, oedema or pronounced asthenia, are to be considered especially poor operative risks. That the time for operation should not be when the patient is in extremis, when the resistance is reduced to the lowest possible ebb and where a fatality seems imminent either with or without surgical procedures, but when a reasonable time has been allowed for the thorough trial of therapeutic measures and before the physical organism has become so completely wrecked as to leave the patient without recuperative force.

The present high mortality following operations for this condition may be ascribed in a great measure to the optimism of the attendant, the disinclination of the patient to submit to surgical treatment, and the tendency to dally with the condition until it is beyond the reach alike of medical and surgical measures.

Of the various methods employed from time to time in the surgical treatment of this condition partial thyroidectomy has proven the most uniformly satisfactory, the choice being between this and sympathectomy. The operation of ligation of the thyroid arteries and exothyropexy having alike proven unsurgical and unsatisfactory. The comparative statistics of Hartley collected from the clinics of Mikulicz, Kronlein, Kocher, Schultz, Friedham and himself numbering in all 156 cases showed cured: 71 per cent; improved, 9.6 per cent; unimproved, 6.4 per cent; fatal, 12.6 per cent. As the result of partial thyroidectomy while the series of 53 cases reported by Balescescu showed cured, 37 per cent; improved, 43 per cent; unimproved, 9.4 per cent; fatal, 11.6 per cent; as the result of sympathectomy which goes to show the superiority of the former over the latter operation, not only from the standpoint of absolute cures, but from comparative mortality as well. The heavy

percentage of improved cases under sympathectomy being based for the most part upon the improvement of the exophthalmos which seems the most striking effect of this operation.

The technique should be such as affords the most speedy removal of the gland with the least possible hemorrhage and trauma of the tissues, great care and gentleness being exhibited to prevent the flooding of the system by absorption of excessive thyroid secretion from the traumatized gland. Primary clamping or ligation of the thyroid arteries and the enucleation performed from within outward, the ordinary Kocher incision being sufficient in most cases.

The dangers from operation in these cases are those of operation on simple goitre, viz., shock, injury to recurrent laryngeal nerve, infection, pneumonia, secondary hemorrhage, heart failure, and effects of anesthesia, plus those previous to the clinical status of exophthalmic disease. Shepherd has again called attention to the common occurrence of dyspnoea and tachycardia so frequently following removal of simple cystic goitres, and also to the high temperature immediately following operation in a goodly number of cases. These are unequivocally due to thyroid absorption and emphasize the need of extreme caution in manipulation of these structures.

CASE REPORT.*

BILATERAL CERVICAL SYMPATHECTOMY IN EXOPHTHALMIC GOITRE.

R. H. MEADE, M. D.,
Great Bend, Kans.

Mrs. J.—aged 32 years. Canadian. Housewife. Born in Montreal, Canada Has lived in Kansas 28 years.

Family History:—Negative.

Previous History:—Did not have the usual diseases of childhood. Menstruated at 16 years of age. She has always enjoyed good health until her present trouble made its appearance. Has given birth to four children

Present Illness:—About eleven years ago she complained of being nervous, especially at the time of menstruation, and also suffered from palpitation of the heart and severe headaches. These symptoms continued for a number of years when she noticed that the thyroid gland was enlarged and that the eyeballs protruded. In a short time after this she was disturbed a great deal by a sensation of heat and sweating in the face and neck, although occasionally the limbs were involved. A few months later a muscular tremor developed in the hands and feet, which was fine in character, but did not affect the head. For the past six months she has complained of sharp shooting pains in the extremities and along the course of the trifacial nerves. Dizziness

*Reported to the Kansas Medical Society at its meeting in Topeka, May 7, 8, 9, 1906.

and headache is marked and persistent. Sleep has been disturbed for the past four months on account of difficulty in breathing in the recumbent position and she complains of a sense of constriction around the chest. One year ago, her family noted that she was mentally depressed and this condition of mind continued until three or four months ago when she became irritable and extremely restless. The irritability was so great that it was deemed advisable by her relations to place her in an institution for the care of the insane.

There was never icterus, diarrhoea or gastric disturbances.

Examination:—December 27th, 1905. No ataxia in the legs, arms or trunk. Knee jerks: right, decidedly increased; left, the same. Ankle clonus absent. Tendo Achillis: right, increased; left, increased. Deep reflexes of the right forearm increased. Left, increased. Right, biceps, triceps and deltoid slightly increased. Left, the same. Masseter, absent. Plantar reflexes: right, increased; left increased. Babinski sign absent. Abdominal slightly increased. Epigastric slightly exaggerated. Sensory phenomena normal. Hearing, taste and smell normal.

Eye:—Pupils slightly dilated and respond to light and accommodation. The exophthalmos has advanced to such a degree that when an effort is made to close the lids the ball is not covered; this condition is known as lagophthalmos and is more pronounced on the left side; Von-Graefe's and Stellwagon's symptom present in both eyes. Lacrimation has been increased. No congestion of the conjunctiva. Vision normal. Fields normal. All external ocular movements good. Fundi: optic nerves slightly congested.

The thyroid is enlarged and over the gland a distinct systolic murmur is heard.

Heart:—Normal in size. Tachycardia is present and the pulse varies from 110 to 140 per minute while she is resting. No cardiac murmurs could be found.

Urine:—Color amber. Specific gravity 1030. No albumen. Sugar present. As she did not improve under medicinal treatment, bilateral cervical sympathectomy was recommended and the operation was performed on January 17, 1906.

Bilateral extirpation of all the cervical ganglion was done at one sitting. The incision was first made on the left side. The superior ganglion could be entirely removed. After the completion of this part of the operation, the pulse, which was 140, dropped to 64 and again reacted to 90. A second drop was again noted when the ganglion on the opposite side was removed, to 60 and a reaction again in one hour after the operation to 84. Two hours after the operation the lagophthalmos had entirely disappeared and her eyelids completely covered the ball for the first time in several years; there was no sweating over the face and neck as was always present, and her cheeks looked pale. Twenty-four hours after the operation, the patient had slept well and described the feeling of tension as having disappeared; her pulse had not been over 96 and was 88 when counted in the presence of physicians and nurses, which would have a tendency to increase it. When asked to hold out her hand, the tremor was much less marked. Von-Graefe and Stellwagon's symptoms had entirely disappeared. Thirty-six hours and forty-eight hours after the operation the conditions were about the same.

Five days after the operation the exophthalmos was not nearly so marked. Her general nervous symptoms were much better and she felt perfectly satisfied with the operation. On the sixteenth day, she was discharged from the hospital in apparently good health. Her pulse was rarely over 84 and the exophthalmos was not noticeable. Her nervous symptoms seemed to have completely disappeared. On February twenty-eighth, she had gained twenty-five pounds in weight doing all her own work, and her husband was quite happy at the result. Her pulse then, after coming up a flight of stairs, was 90, absence of all her symptoms that she had complained of before the operation except a slight degree of exophthalmos. On April 26th, her pulse was 94. She was not nervous to speak of and said she felt perfectly well. The goitre was not noticeable, there is still a slight degree of exophthalmos. Von-Graefe and Stellwagon's symptoms absent. I consider this case as cured as far as the symptoms are concerned for which she sought relief.

INFECTED WOUNDS.*

S. STEELSMITH, M. D.,
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The cause of infection is the reception of one or more varieties of the pathogenic organisms into a wound or abrasion.

The prophylaxis of infection consists in the exclusion of pathogenic organisms from a wound or their removal or destruction when once they have gained access to it.

When confronted with a wound regardless of its extent make it as nearly as aseptic as possible. The use of the soap and sterilized water is often sufficient. Of the different soaps, I know of none equal to synol soap. After rendering a wound aseptic, then close it if possible, allowing for drainage if the conditions seem to demand it, then cover it with a dry dressing recently made sterile.

If you have question of your asepsis of surrounding skin, sprinkle over it some antiseptic powder, preferably subgallate of zinc. To those who have never used subgallate of zinc, I ask to try it on any wound. It is non-irritating, non-toxic, inodorous, a thorough antiseptic and a dryer or absorbent. I have used it for 15 years almost exclusively and have but one objection to it, that is, if there is oozing from the wound it makes a very hard scab.

Confronted with a septic wound, we should first consider the source of infection and if it be of some of the highly dangerous diseases, excision might be considered. For example, last February a girl

*Read before the Kansas Medical Society at its meeting in Topeka, May 7, 8, 9, 1906.

9 years of age presented herself with papule on front of wrist, $\frac{3}{8}$ inch in diameter, elevated $\frac{1}{8}$ inch above level, slightly umbilicated with very small vesicle in center, secreting seropurulent fluid,—temperature $102\frac{1}{2}$; pulse 110. A red line ran from papule to axilla. The mother said it was a blister, size of pin head three days ago. She had chill day before seeing me.

It looked to me like anthrax. I excised the papule and just below axilla incised skin two inches and divided all lymphatics engaged in carrying the infection, also some of the veins in proximity to diseased lymph vessels. The temperature promptly dropped to normal and so remained. The wounds healed promptly. The red line disappeared, and all went well.

In the treatment of an infected wound (and all wounds, regardless of size or extent are to be considered infected unless made under aseptic conditions), consider the source of infection, the possibility of the existence of the tetanus bacillus or other highly destructive micro-organism. During my professional career, I have been called to treat ten wounds of the face and head from the kick of a horse. Three of those before the end of the fourth day were well pronounced cases of tetanus. Two died. One recovered. I have therefore resolved to cleanse all wounds as thoroughly as possible with soap and water and then apply a saturated solution of carbolic acid and wash the acid out with alcohol and dress the wound with a 5% solution of carbolic acid and not close the wound until the lapse of several days.

The treatment of cases wherein the infection is being transmitted by the lymph system which is denoted by the appearance of the red line extending from the wound toward the body, should be by ligation or incision of the lymph vessels in immediate vicinity of the red line.

A case in point was that of myself during the fall of 1898. At 5:30 p. m., while attempting to antevert a retroverted uterus for a patient suffering with metrorrhagia, who also had a discharge with a foul odor resembling the lochia after parturition, I pricked the top of my forefinger with a sharp pointed tenaculum. It was a mere prick and although while intending to apply some antiseptic, I forgot it. I was driving in the country that night at 1:15 a. m.—7 hours and 45 minutes after the injury and my finger became quite painful. I stopped on the road and with the aid of the buggy lantern I reopened wound and I was surprised to find good sized drop of thick pus. At 8 a. m.,—14 $\frac{1}{2}$ hours after the injury I had a rigor and sense of stiffness in arm and forearm. On examination, a bright red line extended from anterior wrist to axilla with slight tenderness of lymph glands in axilla. Temperature and pulse arose and at 2:30 p. m.,—21 hours after injury, tempera-

ture was 103 and pulse, 120. My anxiety probably increased pulse rate. Realizing the virulence of the toxic agent, I finally decided to prevent further advance of the trouble by dividing the lymph vessels which I did through an incision by using a strabismus hook and scissors. I used carbolic acid in wound of finger also.

Very promptly red lines faded and temperature and pulse resumed the normal. I had no more trouble until the end of six days, when the wound of finger seemed a very trivial affair and since an operation for a patient seemed imperative I cleansed finger thoroughly and sealed it up with tissue rubber. About 12 hours afterward I observed a sense of stiffness in arm and a red line this time to the radial side of the former site was very distinct. Being away from home and without proper instruments, I used needle and thread ligating lymph vessel near axilla, after which, all trouble subsided. My temperature this time was 100°.

I believe that if the patient is seen prior to the invasion of the lymph and blood vessels and the wound drained and the infected member be kept at perfect rest and covered with a thick dressing of gauze, kept constantly moist with some antiseptic solution,*there will be no abscess formation or extension of the trouble to other parts through the blood or lymph vessels.

I consider that perfect rest of the arm and forearm and hand is as important as the medical or surgical treatment.

If an abscess has formed, be careful in your manipulation of the part. Don't be in too much of a hurry to evacuate the abscess, remembering that the longer you wait the less virulent the infection. Be careful in making your incision to evacuate abscess that you injure no important structure or transfer the infection to a new site; more especially should you avoid the sheaths of tendons. In some instances pus will form within the sheaths of tendons or it may burrow within the sheath following which, you are very certain to have a contracted tendon; more especially is this the case if it be the flexor tendons of the fingers which are involved.

I do not know if it be possible to prevent this contracture of infected tendon sheaths. If we discover the condition sufficiently early and secure free drainage at both extremes of the affected part and succeed in irrigating the canal so formed with a 5% solution of carbolic acid, or some other antiseptic, we may hope to prevent a subsequent contracture. I am partial to the use of a 5 per cent carbolic solution in the irrigation

*A good solution for moistening dressings is made of 5% solution carbolic acid, 1 part; saturated solution boracic acid 4 parts; alcohol (95%) 1 part. Equal parts of camphor gum and carbolic acid crystals warmed together to form a liquid, form another excellent antiseptic.

of infected joints and believe we should obtain good from its use in the irrigation of infected tendon sheaths.

In connection with the treatment of the local conditions, we should in certain cases make use of the hot air cylinder; the cases most benefited are those with local oedema and stasis of blood and lymph. Skin, bowels and kidneys should be made to perform their functions in the eliminative process of the toxins.

DISCUSSION.

DR. KENNEY: It would be presumptuous on my part to measure words with the essayist here. I have not had a wide experience in infectious wounds. I believe castile soap is as good any other to give the wound a thorough cleansing. I then use a solution of bichloride of mercury, but not stronger than 1 to 2500. If the infection is spreading up the arm I usually put it at rest, and if I get it early I put on an ice bag. The very moment I find a pus formation, or as soon as I make a diagnosis at all, I find usually open it up lengthwise clear down, and I have never yet had a case of necrosis of the bone. In this trouble which resembles anthrax, which usually comes on with a little papule, I have had the whole thing slough out as large as a quarter. I had a case that within twenty-four hours, the temperature reached 102°, with rigors, and with a red streak running up the arm as wide as your two fingers. I have made a practice of putting patients at rest, giving them a good cathartic. If they can stand it I curette and mop out the wound with carbolic acid followed with alcohol. I then put on a dressing of a solution of bichloride of mercury. If there is any oozing, I usually thoroughly wash out and then dry thoroughly, then put on a powder of equal parts bismuth subnitrate and boracic acid. There is one point that always worries me, and that is where children step on nails in the summer time. The wound usually closes up and we are apt to have a case of lock-jaw. In these cases I usually scrub the outside of the foot. If you take your hypodermic syringe and inject some carbolic acid, then dilute alcohol, you will get a thorough cleansing of the wound. I do not know but what I will get up against it some time, but this treatment has always proved satisfactory to me.

DR. BLASDEL: This last paper is not a specialist's paper. In these cases we do not have to send for the specialist, as Dr. Davis said yesterday. There was one thought that suggested itself to me, and that is the wounds from toy pistols, etc. I think we can afford to open up these wounds and drain them thoroughly in a hundred cases to save one case that might be infected. It is the thousandth case probably that develops tetanus. Of course, the first thing is prophylaxis, but if the case is not seen until infection has taken place, the infected member should be put absolutely at rest.

Nothing has been said about the use of alcoholic stimulants in septic conditions. They may be used and pushed almost to the point of intoxication with good results.

DR. MINNEY: I have nothing new to offer to the questions asked. I was very well pleased with the paper on exophthalmic goiter. We have to deal with it occasionally and don't know what to do with it. I have never seen a case of it cured that I know of that was well pronounced. The doctor is to be congratulated on his results. I have have been told in cases of glaucoma that the removal of it does relieve the tension of the eye.

Did you examine this sympathetic ganglion after you removed it, and second, to what do you attribute the shrinking of the eye? I would like to know the statistics of cure in exophthalmic goiter and how general the operation is.

DR. SUDLER: In reference to exophthalmic goiter, Dr. John Rodgers of Cornell

Medical College has recently had some very interesting work done along the line of serum therapy for this particular disease. His interest was drawn to it from the fact that a member of his family was a sufferer from it. In one of the large hospitals with which he is connected there was an autopsy on a victim of this disease. He took these thyroid glands and turned them over to Doctors Park and Bebee of New York, and they injected emulsions of them into two large rabbits with a view to producing an antibody and they seem to have succeeded. The idea of trying it by serum therapy was not a new one, but heretofore, the thyroids used were those from healthy goats or sheep and this was the first time that glands from a human subject that had died of exophthalmic goiter had been used. His results on the limited number of cases on which it has been used are striking, showing as they did a high percentage of apparent cures and improvements. It was tried on about twelve cases in all, and, in all but two, marked benefit or apparent cure resulted.

DR. DORSEY: The doctor's remarks remind me of a couple of reports that I saw coming from the west, where accidentally treating a patient suffering from exophthalmic goitre for diphtheria they had apparently cured the goiter by the use of the diphtheritic anti-toxine. The improvement was so marked that the parties had followed it up with good results afterwards. I merely report it as worthy of looking after.

DR. SCHAUFFLER: Somebody asked for the statistics of exophthalmic goiter. I cannot give them straight out, but I have a strong impression of the general trend of comparative statistics. The results of the Mayos of Rochester was thirty per cent of cures—thirty per cent of bona fide cures. The mortality from the operations seems to be less than it was before there patients were exposed to X-Ray treatment for a little while before operation. Causes and effects are still confused in this disease, but it seems to be the consensus of opinion that it is due to over secretion of the thyroid gland. One of the principal coincident changes is observed in the cervical sympathetic. When you remove the cervical sympathetic nerves and ganglia, you cut off one of the principal sources of the symptom complex and perhaps diminish the secretion of the thyroid, through vaso-motor change which affect its blood supply.

DR. MEADE: I am not sure that I can answer Dr. Minney's questions. I realize that the operation is not generally done, but in looking over literature on the subject, I find that the removal of the cervical sympathetic ganglia, has given better and more permanent results, with less danger, than usually follows the removal of the thyroid gland.

I saw Dr. Freeman of Denver do the operation for epilepsy and do not think so far as the operation is concerned it is as difficult as the removal of the thyroid. Just what course to reduce tension I have failed to find any authentic information, and cannot positively state. The ganglia kept up some irritation, which causes tension.

DR. STEELSMITH: I will simply reply to all the questions that were brought out in connection with my paper, by saying that there are many methods of treating infected wounds, and no one method is probably applicable to all. Simply the rest cure might be sufficient in a great majority of cases. I believe in some of the more highly infected cases wherein there is danger of the infection destroying life, the proper thing is to either ligate or incise the lymph or blood channels that carry the infection to the body.

SUBINVOLUTION AS AN ETIOLOGICAL FACTOR IN DISEASES OF WOMEN.*

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Subinvolution may be properly classed under two heads, namely, puerperal and menstrual subinvolution. The former is defined as "an arrest of the physiological process of involution which takes place in the uterus after labor or abortion, and by means of which the organ returns to its normal size and weight." The latter is defined as being "an arrest in the subsidence of menstrual development and engorgement causing a persistent enlargement, and due to some irritation or inflammation existing at the time of menstruation." It is of the former condition,—Puerperal Subinvolution,—I wish to speak at this time.

Realizing the fact that this subject is a broad one, and presents a wide field for writing and discussion, I shall confine myself to a consideration of some of its immediate effects only, and shall speak of its prophylaxis, rather than of its after care and treatment.

The uterus is an organ which is richly supplied with blood vessels, nerves and lymphatics. Besides being subjected to active periodical physiological congestion, it is one which should have most careful attention at all stages of life, but more especially during gestation, labor and parturition.

As soon as conception takes place a wonderful stimulation is exerted upon the uterine fibre cells, which grow very rapidly, according to the requirements of the increasing contents of the uterus, which growth ceases only when pregnancy terminates. Parturition may occur at any period of pregnancy, and almost immediately after, a retrograde evolution, or what is known as "involution" begins to restore the organ to its original consistency and size.

The first step in the process consists in the supply of blood being greatly diminished by the post-partum contractions. These contractions continue, while fatty degeneration of the muscular fibres and absorption completes the process. The fully developed fibres begin to undergo fatty degeneration and absorption about the fourth day subsequent to delivery. A new formation of muscular tissue is recognized about the fourth week. The process of retrograde evolution may be retarded or arrested, the uterus remaining large and flabby, and its walls very vascular,—when it is said to be "subinvolved."

The average unimpregnated uterus measures about $2\frac{1}{2}$ to 3 inches in length, and weighs about $1\frac{1}{2}$ to 2 ounces. At full-term pregnancy, it has so immensely grown and enlarged as to weigh 24 to 36 ounces, and to measure 12 or more inches in length,—stimulation and growth commencing as soon as the ovum enters the uterus, and continuing uninterruptedly until after delivery.

If delivery is followed by normal uterine contractions, the uterus will very shortly decrease so as to measure only about one-half its length while in the full-term pregnant state; and to one-fourth its length, and weigh about two or three ounces at the end of the first month. By the

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end of the second month it will have diminished to about its original size and weight.

It has been demonstrated by careful intrauterine measurements taken at varying intervals up to the 10th and 12th weeks that there is a steady diminution up to a point when the dimensions of the involuting uterus are really less than those of the unimpregnated organ. Later, its size, by subsequent engorgement of the uterine vessels, is permanently increased to a slight degree.

Now here is an organ which is to decrease as much in size in two months, as it has increased in nine,—a function which if performed perfectly, must certainly have no obstacles to overcome.

It is only within the past twenty-five or thirty years that the Germans, who first described this subject, gave to us a perfect understanding of the process by which the uterus in nine months' time could enlarge from 2½ inches in length so as to contain one child, and in some instances many children,—and then within two months after delivery, undergo so rapid an absorptive process as to return again to its original size.

A perfect knowledge of such changes is essential for properly comprehending the etiology, pathology and management of a subinvolved uterus. Arrest of involution in the puerperal uterus is an occurrence of very great frequency. It constitutes the chief cause of all chronic uterine disorders, and for this reason alone its care and treatment cannot be overestimated.

Thomas and Munde in their work on Gynecology say: "As a general rule, areolar hyperplasia, the so-called chronic metritis, is a consequence of subinvolution." This constitutes the explanation of the fact that so many women suffering from uterine trouble, date their weakness back to child-birth, and why so many who were perfectly well previous to that period, are semi-invalids afterwards.

As sub-involution serves as the starting-point of so any intrapelvic disorders, it is important that the obstetrician should recognize its presence, and correct abnormal conditions in its early stages. It is not a difficult matter to make an early diagnosis of subinvolution, and its early recognition is of the utmost importance. Unfortunately, however, the diagnosis in its later stages is too often left to the gynecologist.

Following abortions, miscarriages, and labor at full term when it has been abnormally rapid or slow, very frequently a proper involution does not take place. The post-partum contractions being deficient, the bloodvessels remain dilated; the free arterial flow is not much diminished, but the venous flow is very greatly lessened, producing a state of passive congestion. The vascular and muscular tissues fail to regain their elasticity, and contractility, consequently the organ remains enlarged, soft hyperaemic, and flabby, and free to bleed.

Subinvolution is more prone to follow abortions and miscarriages than normal labor at full term. After the normal termination of pregnancy the uterine tissue is fully grown and ripe; hence, its natural tendency is to resume its normal condition; but after an abortion or miscarriage, although the ovum has ceased to grow, the uterine tissue, not being fully ripe, is not prepared for the expulsive event; consequently it remains large, while the patient herself is not likely to exercise the same

care as would be natural after a normal utero-gestation,—and, moreover, the stimulation of lactation is absent.

It is a well-recognized fact that women who either from necessity or otherwise do not nurse their children are much more likely to develop sub-involution, thus supporting the belief in the close relationship existing between the uterus and the mammary glands. The physiologic stimulus of nursing excites contractions reflexly through the mammae and favors involution. Oftentimes when uterine contractions are weak or absent, and the placenta is slow in being thrown off, the placing of the infant to the breast may bring on vigorous contractions and effect its expulsion. Such being the case, it is not all at difficult for us to figure out why it is that the woman who nurses her infant is the most apt to be well-balanced both physically as well as mentally. Unless there is an absolute contra-indication, a mother should nurse her infant, even though the supply of nourishment be scant, and supplementary feeding have to be resorted to.

The subinvolved uterus is soft, flabby and enlarged as a whole, with its adnexa. The cervical canal and uterine canal are dilated and patulous; the endometrium is studded with vegetations, or it may be that the placental villousities left after delivery have not disappeared. The swollen endometrium and vegetations become a bleeding follicular, fungoid condition, hence, at the menstrual epoch there is an exaggerated flow which oftentimes continues intermittently for several weeks, and even months. In this case, if of longer standing, there may be a constant secretion and discharge of a dark brown fluid, which has a coppery or metallic odor.

The prophylactic treatment consists in the complete evacuation of all secundines after labor; the avoidance of lacerations and of infection; and rest in bed until the uterus and cervix are firmly contracted and greatly reduced in size. Indeed, I might go back farther and say that the prophylaxis of subinvolution should begin at conception, or as soon as pregnancy is diagnosed. Our pregnant woman should be kept in as perfect physical condition as possible, and especially when nearing the time of delivery. Plenty of out-door exercise and fresh air, good nutritious foods, aided by tonics when indicated, should be enjoined, and are all very essential. All stages of labor should receive most careful attention. The most satisfactory cases in my own experience are those that I have had under observation for some months previous to delivery, and the most troublesome and unsatisfactory ones have been those not seen until active labor had commenced.

For normal involution to take place, perfect rest in bed should always follow any utero-gestation. The woman who rises too soon and resumes her usual occupation is running a grave risk which may cost her her life, or, at the very least, is courting the serious complication of subinvolution,, the results of which are too numerous to mention in detail here.

The average time for the parturient woman in bed is about nine days. This, however, cannot be set down as an iron-clad rule to follow. The physical condition of each and every case must be taken into consider-

ation, and each be a law unto itself; previous history as to general health; troubles, if any, during previous confinements; and the character of the present or last confinement,—each has its bearing.

Retroflexion is a very common displacement which is developed during the puerperium, which greatly retards normal involution,—and may be due to any one of, or combination of causes, such as, septic or specific infection; laceration of the cervix; laceration of the perineum; getting out of bed too soon after delivery; lying constantly on the back, and the use of a tight bandage after labor.

1. Infection of the uterus during the puerperal state arrests involution at once, and if not checked the organ becomes subinvolved.

2. A cervical tear interferes with the retrograde changes necessary to restore the organ to its normal size, and hence is a primary cause of subinvolution.

3. A laceration of the perineum interferes with the balance of power in the mechanism of the uterine support, hence may be a cause of subinvolution.

4. A prolapse or retrodisplacement is a primary cause of subinvolution; so long as the organ remains at its normal level in the pelvic cavity the venous flow of blood is unimpeded in its course, and normal involution progresses uninterruptedly.

5. Getting out of bed too soon results in displacement, because the uterus at that time is too heavy for its ligaments, hence, they become over-stretched, allowing the organ to fall backward and downward. Lying constantly on the back, and the constriction of a tight bandage are common causes of displacements, and cannot be too strongly condemned. Under these conditions the heavy, enlarged and softened uterus is acted upon by specific gravity, as well as the constricting band, and gradually settles backward because its ligaments for a time after labor are so stretched and elongated that their function as tether ropes is temporarily lost. (Ashton).

Accepting the fact as true that the uterus is still heavy and enlarged during the second month subsequent to delivery, we cannot but understand and recognize the danger of following out without deviation this nine-day rule, as in many cases this would be altogether too soon to allow the patient to even sit up too persistently, being entirely too early for the erect posture. Therefore, if we are unable to establish a law governing the bed of all parturient women, and are unable to decide which cases require confining longer than the stipulated period, then it seems to me that we would be very much safer to confine them all longer, there being much less harm imposed upon those who are unnecessarily kept in bed than upon those who are allowed to rise too soon.

Considering the subject of subinvolution a most important, as well as a most neglected one,—acting as it does as an etiological factor in so many morbid conditions arising among women,—I shall feel amply repaid for my efforts in preparing this paper if it does no more than to elicit some discussion which will set us thinking along this very important line

TUBERCULOSIS.*

Its Prevention and Restriction.

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That insidious disease which we call consumption, phthisis or tuberculosis of the lungs, is the most terrible destroyer of lives with which civilization has to contend. At the present time, the fact of the infectiousness of consumption is firmly established in a scientific way, and enough is known of the natural history of the infective agent, the bacillus of tuberculosis, and of the ways in which it is communicated to man to enable us to lay down rules for the prevention of the disease with more positiveness than was formerly possible. The source of infection is two-fold; from one human being to another, and from tuberculous animals to man. The tuberculosis of man and consumption are of the same nature. From the domestic animals, there is danger of contracting the disease from use of flesh, and especially by the use of milk from those which are tubercular. Many children die in their earlier years from various tubercular diseases; tubercular inflammation of the brain, "consumption," etc. Many of those deaths are due to living amid infectious surroundings and breathing infected air, but a considerable portion die from infection received in the milk of tuberculous cows, or in that from mothers suffering from tuberculosis in some form. By far the greatest source of infection, however, is from consumptive human beings; but fortunately, the ways in which the contagion is disseminated are but few, and by intelligent care, may be effectually controlled.

From the human source, we may consider the expectoration as practically the one great danger. The consumptive sputum usually contains an abundance of the infection, the bacilli. These microscopic organisms are found to be capable of retaining their vitality and infectious qualities for a long time, even after the sputum has been thoroughly dried. As a general proposition, the statement is true, that the breath of the patient is not infectious and the same may be said of

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the sputum as long as it remains moist. Later experimental work, however, indicates a possibility of infection in the immediate vicinity of hard, open-mouthed, coughing. Another line of investigation has proved that the careless consumptive patient is a source of infection and a danger to all persons who come much in proximity to him; especially those who dwell in the same rooms with him. The reason of this is that the expectoration of the patient, spit upon floors, carpets, handkerchiefs and clothing, becomes dried and pulverized, and floating in the air, still contains the infectious germs, and cannot be inhaled without great danger. Though infection may be regarded as the principal, the essential cause of consumption, there are, nevertheless, various outward influences which have much to do with increasing the death rate from this disease, and they should never be disregarded. The most important of these are the breathing of impure air; that of unventilated sleeping room, school rooms and offices; the use of food not sufficiently nutritious; and dwelling upon damp soil. Heredity, formerly thought to be a potent cause of pulmonary consumption, and other forms of tuberculosis, is now known to have little part in the causation of the disease. Since the infectiousness of the disease has been shown, family groups of consumptives (house epidemics) are now referred to infection. Though heredity is possible, the best authorities the world over, now teach that cases of hereditary transmission of tuberculosis are rare. The general tendency has been a considerable falling off in the mortality of the disease since 1892. This is a gratifying fact; nevertheless, it is no indication that there is no unnecessary prevalence of the disease. Though our people, more and more, appreciate the wisdom of having a care to prevent the existence of the disease, we are far from the sanitary ideal, which may be reached with comparative ease. There is hardly a limitation to the degree in which the prevalence of the infection may be restricted when our people are pervaded with a dire sense of the enormous financial loss due to the infectious and contagious diseases, and comparatively small expenditure required to save much of this loss. But this work must come from a public correctly educated in sanitary matters and co-operating with the local health officers. Thus, for health officers and all who believe in lessening the tribute which the infectious diseases levy upon our finances, state and private, is the one direction in which the greatest saving may be effected. The plans for the suppression of tuberculosis which offer the greatest promise of good, must include the continued instruction of the public in regard to the infectious nature of consumption and what precautionary measures are required to minimize the danger to others.

In the affected household, trustworthy information on these points

may well be said to be of priceless value; but for the best preventive and curative results, something more than this circularized system of instruction is needed. In numberless homes, the rooms are too few and too limited in cubic air space to make the presence of a consumptive other than a source of serious danger to the other members of the family. Under the conditions which prevail in many a poor, though intelligent, family, with a consumptive member, particularly if children are present, one or more secondary cases are almost sure to follow in due time; though often after a considerable lapse of time.

Under these conditions, it would be a blessing to the families, as well as the patient, if the sick one could have the advantage of proper care and treatment elsewhere. For the incipient cases of consumption, the modern sanatorium treatment offers, by far, the best chance of cure; but aside from this, it sends its graduate patients out as sanitary missionaries. Each one of them has had a systematic training which is invaluable as a safe-guard against the communication of this disease to other persons, whether he goes on to a final cure or not. As to the curative value of the treatment, the evidence of more than fifty years' experience in Germany and twenty years in this country, since the work of the cottage sanatorium began, has been so conclusive that the movement for thus saving the consumptive may well be said to have become world-wide.

Maine physicians send a great many of their consumptive patients into the northern pine woods. There are from twenty-five to fifty patients in the Maine woods at all seasons of the year. They reside in the forest year after year until their lungs begin to heal. After this, if there is no unfavorable symptoms for six months longer, the exile is permitted to visit his friends for a few days, twice a year. At the end of about five years, the patient, if hale and able to work among men, gets a certificate which sets him at liberty. The records show that nine out of every ten, who have been steadfast enough to see the treatment through to the end, have come out cured.

Rules for the Patient.

Two facts should encourage the patient. One is, that there is always an intrinsic tendency to recovery in the earlier stages of the disease, and that under modern treatment, a large percentage of cases recover. The other is, that there is no reason for any person to think that he is doomed by heredity, no matter what his family history may be.

It should be impressed upon all consumptive patients, and other persons living with them, that the sputum is dangerous and must be properly disposed of. It must not become dry. There are several

ways in which the sputum may be safely cared for; pressed paper spit-cups, costing but little, are on the market. One, or several can be used daily and after it has been used, each, cup, with cover and contents, can be burned. A cover should exclude flies. Paper cups held in a metal frame may be used; after use, cup and contents burned.

Metal spit-cups, or spittoons, may be used, each containing a small quantity of disinfecting solution. The final disposal may be through the sewer or by cremation. For this purpose, I have them use a two-per-cent solution of formaldehyde.

When away from his room, the patient may spit into Japanese paper napkins, to be put into a rubber tobacco pouch until they can be burned.

Never swallow the sputum. By so doing, you favor the extension of the disease to the intestinal tract. Do not infect the immediate surroundings of the home, nor spit upon the porches, grass, hay, or elsewhere.

Rules for Everybody.

Anything tending to lower the tone of the general health may act as a predisposing cause; insufficient nutriment, overwork, loss of sleep, worry, close and dusty air. Avoid these. Give sleeping rooms a prolonged airing and sunning by day, and as much night ventilation as practicable. The dwelling-place should be dry. If it is thought that there is a family predisposition to consumption, an outdoor occupation should be chosen. Live in the open air and sunshine as much as possible. An abundance of pure air is the all important thing.

O BACILLUS! O BACILLI!

(With apologies to the memory of Walt Whitman).

I sing the bacillus unending
 Headless, tailless, coming without introduction
 Everywhere in the streets of Manhattan,
 Also, in the streets of Philadelphia—
 The bacillus—small but mighty.
 Wherever the dust blows there he is, O Camaradoes!
 Marching in ranks, without officers,
 Without generals or colonels, or lieutenants—
 Without bands of music,
 Without streaming flags or banners,
 Yet he is on all flags and banners.

* * * * *

Blowing out from the windows of small-pox sufferers
 And the window of the child with German measles—
 On the lips of the young man about town

Also in the cough of the registered consumptive.—
 In the six-gallon can of the milk-man
 And also in the pump by which the milk-man stands
 Carelessly, with his hands in his pockets.
 On the hands of the milk maid,
 And on the hands of the milk-man,
 And also on the patent milking-machine.
 In the juice of the herbivorous cow—
 And on the diphtheria placard at the door of the small two-story house.
 Also sailing the ocean in mammoth ships
 And on small ships,
 Loaded down with cargoes of salt and logwood
 And coal, and dried fish, and articles manufactured
 In Germany and elsewhere—
 And cholera and plague and rats and Beri Beri,
 All waiting at quarantine under the yellow flag.
 He is also in the ocean over which the ship sails
 And in the raw oyster.

* * * * *

When we are asleep equally when we are awake
 And kicking, he waits for us,
 Fearing nothing—and nobody, except serums—
 At the name of “serum” he shudders and she shudders
 Because they know nothing about serums
 Nor does anybody else know anything about serums
 But they shudder.
 They would turn tail, if they knew which end was tail,
 But they do not.

* * * * *

Living and dying, O Camaradoes, he is with us,
 At the dinner table and the festive midnight supper,
 On the fried egg at the drummer’s early breakfast,
 In the mold of the new cemetery
 Before the lots are sold off
 And the undertaker has made his fortune selling the lots.
 There he is, standing on his hind legs looking up—
 There she is, standing on her hindlegs looking up—
 As the undertaker lets us down—slowly.
 No longer, old grayheaded, goat-whiskered—
 Like him we once called “The Grim Reaper.”
 He Raps just the same, but he is not grim.
 He is the friend and little brother now of the biologist,
 Living with him in his laboratory, in culture tubes and incubators;
 Growing in colonies—Pioneer, O Pioneer!
 Growing on jelly—jelly of the feet of calves
 And gelatine jelly and any kind of jelly
 And in blood serums and broths
 And any kind of broths,
 And vegetables and fruits and salads.

* * * * *

Clustering in cheeses, old redolent cheeses—assisting digestion—
 Yet he is waiting to kill us, in the ice-cream at the Sunday school picnic —
 Meeting us at the edge of our cradles—
 Peering at us thro' the cracks of our coffins—
 O brave bacillus, O mighty bacillus, O small bacillus,
 Look out, keep off' We are sprayed with formaldehyde,
 O, libertad, O fiddlesticks.

EDWARD WILLARD WATSON.

Medical Notes and Queries, June, 1906.

CORRESPONDENCE.

Huff, the Cancer Man.

To the Editor:

It was with pleasure and no small amount of gratification, that I read the communication of Dr. Haggart in the November number of the Journal, in which he gives an interesting account of the trial and conviction of a cancer fakir, by the name of Joseph Huff.

The reasons for my feeling in this case, aside from the desire to see the public protected by the enforcement of the laws, are somewhat of a personal character, as my father was one of the victims.

In the summer of 1899, my father, who then lived in Parker, Linn County, Kas., made me a short visit, and during his stay with me, I noticed a small excrescence on the right cheek, which had the appearance at that time of being a senile wart.

I called my father's attention to the growth, and warned him of what it might be eventually, and tried to prevail on him to at once have it removed. As it was not then giving him any trouble, and he, not realizing the serious condition that might subsequently arise, put off having anything done, and promised me, that should it show any tendency toward malignancy, that he would then submit to treatment.

He returned to his home, and I received from time to time, somewhat meager accounts of his condition. During the summer following, he again visited me. The small insignificant looking wart had developed into an ulcer, about the size of a silver dollar, with a tumor about the size of an English walnut protruding from the center. The progress of the growth and ulcer had been quite rapid and was nearing the proximity of the orbit of the right eye, and would soon have involved that organ.

I prevailed on him to go with me and consult Dr. P. D. Hughes, of this city, and obtain his opinion in regard to the proper treatment, and the course best to pursue. We called upon Dr. Hughes, and he at once pronounced it Epithelioma, in which diagnosis I concurred. Dr. Hughes said that he believed that it was worth the effort to endeavor to remove the growth and diseased tissue and try to effect a cure, although he feared that in so doing, the eye would probably be impaired and perhaps destroyed. Dr. H. suggested that we apply caustics to destroy and remove the diseased tissue. My father consented, and a day or so following, Dr. Hughes came down to my office and we began treatment, employing a strong caustic paste, to destroy the epithelial

growth. This method was productive of much pain, both at time of application and for several hours subsequent thereto; so much so that after a few treatments my father said that he could not bear it and begged for an anesthetic. I therefore requested Dr. Hughes to ask Dr. Mabie to accompany him on his next call and anesthetize my father during the application of the caustic. Dr. Mabie came, and used chloroform. While our patient was under the influence of the anesthetic, Dr Hughes removed by the knife the tumorous mass and such other diseased tissue as was discernable. In the subsequent treatments we used the caustic paste to destroy any suspicious tissue as would come to our notice. These methods left quite a large cavity, and even denuded the malar bone, the periosteum being destroyed to the extent of surface equal in size to a silver ten cent piece. However, the wound assumed a healthy appearance, healed rapidly and in a short time was entirely well. There was no disfiguration, no distortion of the features, and no injury to the eye, with the exception of a very slight ptosis of lower lid.

My father then enjoyed good health for several years, with the exception of an attack of Herpes Zoster. I saw him once or twice yearly, and there was no indication of a return of the epithelioma.

In October of 1904, he visited me and during his brief stay, I noticed a small scaly spot on the left cheek about the size of the flat side of a split pea. This condition caused me quite a little anxiety. I mentioned my fears to my father and tried to persuade him to have treatment begun at once. He did not feel so much alarmed as I, and put me off with promises, to submit at once to treatment, should the condition assume the appearance of becoming inflamed and malignant. He went to his home, and I did not see him again for almost a year. In the fall of 1905, I received a letter from my sister with whom my father lived (my mother having died in 1898,) in which she stated that my father's face was causing quite a great deal of trouble. I immediately went to see him. I found him with an ulcer, about the size of a silver dollar, situated on the left cheek. The eye of that side was inflamed and swollen, the lower lid being involved. I was much surprised and alarmed, and asked why I had not been earlier informed as to his condition. I was told that father was afraid that if I knew his condition, that I would insist on again taking him home with me, and subjecting him to the treatment he had before undergone, and while these fears were preying upon him, along came one "Dr." (?) Huff, who represented himself as an expert in treating cancers. Huff told him that he could cure him in a short time, that there would be no pain or suffering of any kind attending his treatment, that he would guarantee a perfect cure, and that he had successfully treated and cured numerous cases much worse than his. The credulity of my father and the remembrance of the suffering that he had endured during his former treatment, made him an easy victim. He paid this fakir \$50.00 and submitted to his so-called treatment. Under the management or mismanagement of this Huff, the condition grew rapidly worse, and still Huff persisted in stating that he could accomplish a cure. until the ulcer began to invade the soft tissues of the eye, then he said that "if it had not got into the eye"

he could have cured it. It was then that my sister wrote me. I found Huff still giving "treatment." He came while I was there and I took occasion to give him my opinion of his ability, and the risks he ran in violating the State Law regulating the practice of medicine. He claimed that he violated no law, as he did not give any medicine, but merely made an "outward" application.

I expressed my determination to prosecute him, but my father pleaded with me so earnestly that I finally promised him that I would not do so.

I persuaded my father to come to come to Kansas City and try the X-Ray treatment, realizing, that the disease had passed beyond the hope of being benefited by surgical interference. He came, and Dr. F. P. Clark assumed the care of his case. Dr. Clark began treatment, and at first, it appeared that there was much ground for feeling encouraged, but owing to his age, (85 years) and his debilitated condition, he began to decline, the ulcer increased in size, and his system becoming infected to a certain extent by the septic material absorbed from the ulcer, he gradually failed and about the first of March he went to his home and was cared for by a local physician till the end came. He grew weaker, the ulcer increased in size, invaded the left side of the nose, and on the 19th day of April he gave up the fight. He was remarkably strong up to the time of his death. He got out of bed every day to have his face cleaned and dressed, to pass urine, and have action of the bowels. There is not the least doubt but he would have recovered if his case had been taken at the time this fellow Huff commenced his nefarious manipulations. Huff is an ignorant man, not even having the advantages of a common school education. He knows nothing of human physiology or anatomy, and does not pretend to know anything concerning the action of drugs, nor their uses, only the one remedy (?) His cancer cure (?). It is remarkably strange, that people with an average amount of intelligence will allow themselves or their relatives or friends to risk their lives in the hands of such an ignorant charlatan, yet 'tis true that people love mystery, and are ruled to a certain extent by superstition. How often we hear someone speak almost with awe and reverence of the wonderful cures performed by some "Indian doctor!" How many there are who believe in "vitalized paper," in "absent treatment," in "magnetic healing," and would rather trust their lives or the lives of loved ones in the hands of some mystic fraud, than to the kind care and consideration of a man who has devoted his whole life to the science of medicine, to the art of relieving suffering, to the task of fighting disease. Yet it is with such conditions that the physicians have to contend, and although discouraging, will keep up the good fight, trusting that eventually the people, or a larger number of them at least, will realize that the laws are not made for protecting a class, but for the good of humanity generally.

Those who condemned the action of the Franklin County Medical Society, for the arraigning and conviction of Huff, would better seriously consider and analyze the motives of that society and also thoughtfully study the law and its objects. No respectable physician or surgeon desires to assume the care and responsibility of treating the disease

commonly called cancer, nor does he seek such cases, but all the profession unite in a desire to protect the public from the rapacious practices of those fakirs, called "cancer doctors," and to that end seek to inform the public of the law.

J. G. POOLE, M. D.,
Kansas City, Kansas.

Another Newspaper Item,—The following clipping and comment is sent us from Independence:

A Remarkable Case.

Sometime ago the newspapers told of a woman who went to Kansas City and had her arm amputated at the shoulder on account of a diseased bone which threatened her life. This, it was declared, was the only hope for her.

On the 5th of last March CALVIN WOODY, the young son of Mr. and Mrs. E. D. WOODY, residing eight miles south of this city, was struck on the left ankle with a baseball while at play. The injury proved far more serious than was at first feared. In a little while, inflammation set in; the boy began to suffer intensely. He passed a fearful summer. When the INDEPENDENCE hospital was opened two weeks ago, CALVIN was brought in for treatment. His leg was swollen to many times its normal size and was black to his hip. He had sinking spells and it was believed he was nearing the end of his life.

DR. SHELTON, on Wednesday, October 10, performed a difficult surgical operation in hopes of saving the boy's life and at the same time give him the use of his limb and though that was less than two weeks ago, it seems as if the operation had been a complete success. DR. SHELTON opened the leg and removed its bone from the knee to the ankle, even taking out the ankle bone. Today the boy is up and around on crutches. A new bone has formed and the wound is rapidly healing. In all probability the lad will be able to get around without crutches in the next two months. His father had no hope of the boy ever getting a free knee again, but the knee joint is just as well as it ever was, and only the ankle will be stiff.

This is a remarkable case and speaks well for for the new hospital.

The comment is as follows: This shows how careful physicians must be in their dealings with newspapers.

"Stripped of its setting, the following is about the plain, unvarnished tale. Young W———— was injured as stated above. The doctor who was called, treated the case in an intelligent manner, and sometime during the spring operated on the boy and removed, so he thought, all of the diseased bone. A second operation became necessary, a condition not at all discreditable to the doctor, as bony lesions are uncertain. It is very discreditable to the doctor that the operation was delayed until the condition of the boy was as described above. Why did he allow such a condition to occur before doing the second operation? It was further discreditable to the doctor that he used a case where blame really lay at his door to gull the public into the belief that he had done anything worthy of merit.

"Dr.S.— is a member in good standing in county and state societies.

A. JOY".

To the Editor:

I have thought for some time that I would write you concerning some of our difficulties in this section of Kansas. I refer especially to the case of Geo. F. Woolgast (you have it *Wilgeist* in November issue of the *Journal*), who has been charged with fraud and deception in obtaining his certificate from the state board. His case came up for trial in June, and before the completion of the trial, and before half the evidence had been submitted by the prosecution, the defendant arose and said: "Gentlemen, I will admit that the affidavit I made to obtain my certificate was false, and that I did not attend college as as alleged in my affidavit." It was given to the board for a decision, and in the face of all the evidence and the admission of perjury by the defendant, the board said that they were undecided upon the question, because of a technicality of law. The attorney for the prosecution then made a proposition that they wait until the next meeting in October and in the meantime he would submit a brief setting forth the law in all its detail, which was agreed to and at the October meeting, they came together with the same unflinching zeal in behalf of the man who had in their very presence said, "I am a perjurer. I used fraud to get this certificate, but still I want to continue to hold it and practice medicine in the great state of Kansas."

What do you think of it, gentlemen?

I know this man well and know that the allegations were true in every particular. The prosecution made good, but the board was resentful and stubborn from the very fact that they showed no disposition from the beginning to give a fair and impartial hearing of the case. This was not at all to be wondered at however, when it was learned that the defendant spent three or days with the board previous to the hearing carrying their grips from place to place and banqueting them from one cafe to another and having a general good time. I am of the opinion that had he been an escaped convict, still wearing his stripes, with ball and chain attached and gave the board the consideration and used the tactics that he used they would have thrown about him their loving arms of mercy and given him protection. It is more than I can understand. They admitted the evidence was sufficient to prove their claims, but thought they were still under obligations to allow him to continue to practice with only three months' attendance at college, which was proved, and an admission to a false affidavit as his credentials to entitle him to a certificate to practice medicine and surgery in the great commonwealth of Kansas.

I should like to hear from you pertaining to the case and any question will be answered freely,

Yours sincerely,

Coffeyville, December 11, 1906.

C. H. FORTNER, M. D.

BOOK REVIEWS.

A *Text Book of Pharmacology* and some allied sciences (Therapeutics, Materia Medica, Pharmacy, Prescription-writing, Toxicology, etc.) together with outlines for laboratory work; solubility and dose tables, etc., by TORALD SOLLMANN, M. D., Professor of Pharmacology and Materia Medica in the Medical department of Western Reserve University, Cleveland, Ohio. Second edition. Cloth; 8 vo; pp. 1070; 127 textual illustrations. Philadelphia: W. B. SAUNDERS & Co., 1906; price, \$4.00.

There are so many books on therapeutics and materia medica that even the instructor of the subject is confused by the multiplicity. The reason for this condition is the interest in the subject on the one hand and the general confusion on the subject on the other. Evidently no one book has met the needs of the day. Evidently also the practitioners of our country are eagerly awaiting the satisfactory text.

It is everywhere admitted that the instruction in our schools on this subject has been woefully lacking both in extent and intent. Few schools have taught the complete action in their varying doses of the individual drugs. Many teachers of internal medicine have been avowedly nihilists; and those who were not nihilists have been sceptics. But the reign of surgery, et al., is passing and a belief in the positive action of drugs is beginning to appear. The demand is for better teaching in the schools and for more exact records of results obtained outside of school.

To obtain this better teaching, we must have both a properly equipped teacher and a properly prepared student. The teacher must unqualifiedly be a physician,—not only so but he must be a physician who knows drugs. Only the physician with professional training, professional experience, and professional feeling can select from the immense mass of material constituting our materia medica the valuable units and can teach students about these units in such a way as to awake rather than stupefy the student's interest in the subject. The student must be led to get first hand, rather than second (or third) hand knowledge. He must be taught to observe and reason, rather than simply memorize. This requires a high grade of pedagogic ability and energy. Then, too, the student must know something of botany and chemistry before he can appreciate the work of such an instructor or of such a course. He should have had also all of his anatomy and histology and at least the simpler parts of his physiology. This puts the course in the second part of the second year, where it should occupy at least two hours (or one full laboratory period) for at least five days in the week.

Granted such a course with such an instructor—the student would be ready to take up applied therapeutics in his first clinical (or third medical) year. In this year he should be taught the technic of giving

drugs, the combination of drugs to meet varying conditions, and then the study of the therapy of each disease. This should be followed in the fourth year by adequate courses in massage and the other forms of photo, hydro, mechanical and physiologic therapy. This part of the work is in our opinion just as important as the drug therapy and should be under just as competent instructors.

Judged from the standpoint of furnishing material for such a course, Sollmann's text ranks rather high in the list of text books on the subject. Wood's textbook gives practically no experimental work and hardly meets the demands of this system of teaching, although its standpoint is experimental rather than empirical. Potter's text is such a scrap book of information, that it can be used only by one who has discrimination enough to discern the valuable from the valueless. Hare's is similar, but less comprehensive, and less generally useful. Wilcox' text appears to be an unsuccessful attempt to meet completely the conditions of a modern course of study. Cushny's is a good student's book for the sophomore course, but would not do for the practical work.

Sollmann has evidently worked out a very definite plan of teaching the subject, for on pages 771 to 791 he gives the details of a course for the sophomore year, wherein even the subject for each lesson is outlined. He then goes on to outline 76 experimental exercises for such a second year course. All this makes his book valuable to the teacher and probably the most useful textbook now published for the use of students.

When we examine the book from the practitioner's viewpoint, however, we must set up other standards. The practitioner uses his text on pharmacology simply as a reference work. He seeks either a list of drugs usable in some condition which is puzzling him; or, he wishes to learn the action of a drug he is using—usually to see if it is producing some of the peculiar phenomena observable in his case. Therefore the indexes are the most important, both of the drug actions and of the diseases in which the drug is useful. A selected list of case histories would also be a valuable adjunct to illustrate the action of the various drugs. The effects on the frog and the rabbit are to the active practitioner of minor importance, for his is not a work of research into drug action, but rather a work of saving human lives by using the results of the experiments and researches of others. He wants therefore, simply a concise statement of the effects of the drug both in health and disease upon the human organism.

Judged from this standpoint, Sollmann's textbook ranks very low, and Potter's and Hare's texts rank higher. Wood's text contains too much of the argumentative and experimental to be interesting to the

average practitioner. Shoemaker's contains too much that is mere hearsay and rumor to be reliable. Wilcox seems not to have his clearly in mind the two different uses of a text and has tried to write both for the student and the practitioner, with the usual result.

Were we then to advise a student in the purchase of a textbook, we would suggest Sollmann; were we advising a practitioner, it would be Potter's. Both of these books are well printed and bound.

Materia Medica, Pharmacy and Therapeutics, including the physiological action of drugs, the special therapeutics of disease, official and practical pharmacy, minute directions for prescription writing and avoiding incompatibility, also the antidotal and antagonistic treatment of poisoning, by SAM'L. O. L. POTTER. Tenth edition. Cloth; 8 vo.; pp. 914; price, \$5.00. Philadelphia: P. BLAKISTON'S SON & Co., 1906.

Genito-Urinary Diseases and Syphilis—A compend which includes their surgical treatment, by CHARLES S. HIRSCH, M. D., assistant in the Jefferson Medical College of Philadelphia. Cloth, 12 mo; pp. 340, illustrated. Philadelphia: P. BLAKISTON'S SON & Co. 1906. Price \$1.00.

This is more than a quiz compound. In fact, it contains enough material on its subject to meet the needs of all except those who specialize in this department.

Retinoscopy in the determination of refraction at one meter distance with the plane mirror, by JAMES THORINGTON, A. M., M. D., Professor in the Philadelphia Polyclinic. Fifth edition, revised and enlarged. Fifty-four illustrations, ten of which are colored, Cloth, 8 vo.; pp. 67; price \$1.00. Philadelphia: P. BLAKISTON'S SON & Co.; 1906.

In spite of much opposition, the shadow test in refraction has made steady progress, as the issuance of this new edition indicates. We believe that this method of studying the eye should be at the command of every practitioner who does refraction. It will check his ophthalmoscopic work and certainly aid him greatly if he be lazy and inclined to depend on subjective tests. This text is probably the clearest exposition of this method published in English.

Rythmo Therapy: A discussion of the physiologic basis and the therapeutic potency of mechano-vital vibration, to which is added a dictionary of diseases with suggestions as to the technic of vibratory therapeutics. Illustrated. SAMUEL S. WALLIAN, A. M., M. D., of New York. Cloth, 8 vo.; pp. 210. Chicago: THE QUELLETTE PRESS, 1906.

To those who like speculation and mysticism, this book will be interesting, for instead of using the inductive method to build up a new department of therapeutics, the author uses the deductive. Thus on page 20 we find the following postulates:

".....and matter becomes a visible and palpable manifestation or entity only when combining or combating motions or forces of some kind are brought in contact."

"If we admit this last postulate of science, it may be reiterated that matter is merely a modality of motion, a variety of vibration, whose rate of vibration are both invisible and incomputable,"

Vibratory treatment is simply in its infancy and we cannot generalize, as this author does, for many days yet.

The Physician's Visiting List for 1907. LINDSAY & BLAKISTON. Fifty-sixth year. Small 12 mo., leather with flap, pp. 24 of text plus the pages for memorandum, etc. Philadelphia: P. BLAKISTON'S SON & Co., 1907, price \$1.00.

To prevent loss of money, to promote care in recording one's work, this pocket book (or one very like it) is almost essential. This one is well made and thoroughly commendable, and is of very convenient size.

The Practitioner's Visiting List for 1907. A pocket-sized book containing memoranda and data important for every physician, and ruled blanks for recording every detail of practice. The Weekly, Monthly, and 30-Patient Perpetual contain 32 pages of data and 160 pages of classified blanks. The 60-Patient Perpetual consists of 256 pages of blanks alone. Each in one wallet-shaped book, bound in flexible leather, with flap and pocket, pencil and rubber, and calendar for two years. Price by mail, postpaid, to any address, \$1.25. Thumb-letter index, 25 cents extra. Descriptive circular showing the several styles sent on request. LEA BROTHERS & Co., Publishers, Philadelphia and New York, 1906.

NATIONAL MEDICAL LEGISLATION.

DR. LUTZ' REPORT.

Dr. L. L. Uhls,

President of the State Medical Society,

Osawatomie, Kansas.

DEAR DOCTOR:

I attended the Annual Conference of the Committee on Medical Legislation and the National Legislative Council of the American Medical Association at the New Willard Hotel at Washington, D. C., on December 13, 14 and 15, 1906.

I regret very much that I did not know of my representing the State Medical Society sometime beforehand, as I only received notice in the forenoon, and five hours afterwards I had to take the train to be there on time.

The establishment of a Department of Public Health with representation in the Cabinet with the title of "The Secretary of Health," the advocacy of a measure for the relief of Dr. James Carroll of the United States Army, one of the martyrs of the yellow fever investigation in Cuba, and the approval of uniform state laws for the control of quackery and charlatanism, the Army Medical Reorganization Bill,

and the Osteopathic Bill for the District of Columbia, and the necessity for uniform legislation by the states relative to the purity of food and drugs were amongst the most important matters under consideration. Dr. Chas. A. L. Reed of Cincinnati, Ohio, acted as Chairman at the deliberations of the Council. Twenty-two states and three members of the committee on Medical Legislation of the A. M. A. were represented.

Relative to the pending bill for the relief of Dr. Carroll, he said "The ultimate completion of the Panama Canal, the present salubrity of Cuba, the safety of our Southern seaboard against periodical invasion by epidemics, the maintenance of life and health of our citizens in that great section, and the stability of our national commerce against disturbance from the same cause, are all made possible by the discovery that the mosquito is the carrier of the contagion of yellow fever. As a result of that experiment on one of them, Dr. Jesse W. Lazears, within the next few days died a martyr's death; the other, Dr. James Carroll, survived to live a martyr's life. The only reward that he has so far received, is a disease of the heart, as a result of the yellow fever that he voluntarily contracted for the welfare of his race. This man—this hero—after risking his life to give this priceless boon to the world, after incurring a permanent invalidism in that cause; after having spent thirty-four years in the faithful service, his payment to remain only as an Assistant Surgeon with the rank of First Lieutenant in the United States Army. With the paltry salary of an officer of this grade, and with broken health, this man, now far past the meridian of life, is supposed to meet the obligations resting upon a husband, the father of seven children, and to provide against the requirements of old age.

The bill for his relief indorsed by this Council at its last conference, was introduced by the Senate, but has never been reported out of committee. This is a shame. Surely if congressmen understood the effects of this case, the bill would soon pass within an hour by concurrent action of both houses. To permit it longer to slumber, will be to bring the blush of humiliation to the cheek of every intelligent and grateful citizen of the republic.

The annual address of Dr. Reed covered a number of important subjects as already indicated above. he also urged that there be concerted action in the various states to anti-tuberculosis Legislation.

Dr. Barchfeld, Representative from the Thirty-second Pennsylvania District, spoke on the Department of Public Health, and submitted the original draft of the bill which he had drawn up for the purpose of creating such a department. Prof. Irving Fisher of Yale University, Chairman of the national committee of one-hundred, created by the American Association for the Advancement of Science for the purpose of

popularizing the movement for a Department of Public Health, also spoke on the subject. The bill presented by Dr. Barchfeld was referred to Prof. Fisher's Committee of One hundred, which will get the bill into shape for presentation to Congress.

Representatives of the Medical Society from the District of Columbia appeared before the conference and presented their protest against the enactment of the proposed Osteopathic Bill, and asked the aid of the Council and through the Council that of the medical profession of the country in defeating it. The question was referred to a special committee of three physicians being representatives of the medical profession in Congress, and this Committee will have full power to act. It was also requested that we take the matter up in the different county and district medical societies urging the different members in Congress to oppose this bill.

The Committee appointed to wait upon Speaker Cannon and urge the passage of the medical bill, reported that "Uncle Joe" is favorable to the measure and that the bill will be passed during this present Congress.

Hon. W. B. Heyburn, Senator from Idaho, who was present, made an address in which he denounced the many so-called "patent medicines" now on the market, and said: "That it is only a matter of time when the legislatures will exclude them from the mails." He pointed out the danger of not having legislation regarding the time meat should be kept in cold storage, saying at the present time it was kept on ice much longer than it should be, and that it is often saved from actual decomposition by being treated with a solution of boracic acid. He remarked in closing, that the co-operation of the physicians of the country is necessary to obtain proper legislation.

On the last day of the conference, the members of the council went to the Capitol, calling upon the various Congressmen and visiting some of the committee rooms.

Permit me now to advise the following:—

Appoint your representative for the next annual conference early. He should be acquainted with the laws, rules and regulations of the Board of Health for the State of Kansas as well as other States. He should know the requirements of the medical board of examination and registration of this and all other states. He should have a knowledge of "requirements of osteopaths" to practice the "Beautiful Art of Massage." He should understand the national pure food and drug laws and such other matters pertaining to medical legislation, as needed here and throughout the states.

Thanking you for the honor conferred on me in choosing me your representative for the last conference, I remain,

Yours fraternally,

E. J. LUTZ.

Kansas City, December 20, 1906.

THE OFFICIAL PROGRAM.

OPEN SESSION.

THURSDAY, DECEMBER 13.

10 O'CLOCK A. M.

Call to order and address by the Chairman.

10.30 A. M.

(1) "A Department of Public Health."

(a) Hon. J. C. Spooner, U. S. Senator from Wisconsin.

(b) Hon. A. J. Barchfeld, M. D., Member of Congress from the 32nd Pennsylvania District.

(c) Prof. Irving Fisher, Professor of Political Economy, Yale University, New Haven, Conn.

12 M.

(2) Delegation from the Medical Society of the District of Columbia on the Osteopathic Bill.

2 P. M.

(3) Report of Standing Committees:

(a) Army Medical Reorganization Bill—C. S. Bacon, Samuel Bailey, G. K. Purvis.*

(b) Pure Food and Drug Bill—A. S. Von Mansfelde, J. S. Fulton, S. D. Presbrey.

(c) Department of Public Health—S. D. Van Meter, C. Z. Aude, G. E. Seaman.

(d) Regulation of Medical Practice at Hot Springs—W. H. Sanders, C. T. Drennen, O. B. Mayer.

(e) District of Columbia Bills—G. N. Acker, J. T. Fulton.

(f) Hammond and Canteen Bills—H. L. E. Johnston (Special Committee by request).

OPEN SESSION.

FRIDAY, DECEMBER 14.

9:30 A. M.

(1) "The Necessity for Uniform Legislation by the States relative to the Purity of Food and Drugs."—

(a) Hon. W. B. Heyburn, U. S. Senator from Idaho.

(b) Hon. Nicholas Longworth, M. C., 1st District of Ohio.

(c). Dr. W. H. Wiley, Chief of Bureau of Chemistry, Department of Agriculture.

(2) Discussion:

2 P. M.

Visits to Departments and to Congress.

SATURDAY, DECEMBER 15.

9:30 A. M.

Executive Session.

Adjournment.

SOCIETY NEWS.

The Republic County Medical Society met at Belleville, November 15th, 1906, in the office rooms of Dr. J. C. Decker.

A goodly number of members were present and both afternoon and evening sessions were well attended. A very interesting program had been prepared and from the amount of discussion, each member had not only given careful and studious attention to his own subject but had also refreshed his mind on the other topics.

Two applications for membership were presented, one of which was rejected. The new officers elected for 1907 were: President, J. D. Johnson, Republic; Vice-President, J. W. Ekblad, Scandia; Sec.-Treasurer, J. C. Decker, Belleville. Members present: C. M. Arbuthnot, J. S. Billingsley, J. C. Decker, W. G. Haning, Wm. Kamp, and W. I. McFarland, Belleville; T. C. Long, Munden; J. W. Ekblad, Scandia; J. D. Johnson and D. E. Foristall, Republic; F. Wilcox, Hubbell, Neb. Visitors: F. J. Peter, F. C. Hall, Cuba; W. J. Spohn, Chester, Neb.

After the close of the evening session the physicians, many of them accompanied by their wives, enjoyed a social gathering at which refreshments were served.

WM. KAMP,

Secretary

Shawnee County: Following is the newspaper account of the annual meeting, sent to us by Dr. Judd.:

The general public's idea of a doctor is a very dignified gentleman who constantly exhales the atmosphere of drugs and seldom cracks a smile. But those who passed the Glen-Wood Hotel last night and took a look at the members of the Shawnee County Medical Society and their wives seated around the long table in the hotel dining room formed an entirely different opinion. The attendance was practically limited to members of the medical profession, and consequently the doctors told stories on each other that they would probably have refrained from in public.

The first speaker was Dr. S. E. Smith of Grantville, whose subject was "The Coun-

try Doctor, Surgeon and Midwife, too." Dr. Smith said the country doctor is called on to prescribe for not only men, women and children, but also the farmer's live stock, and he said he was not ashamed to administer a hypodermic of morphine to the farmer's horse as well as to the farmer.

James A. Troutman was the only layman on the program and he spoke on "The Lawyer and the Doctor." He "joshed" the doctors good-naturedly about the popular conceptions of the medical profession and was as uncomplimentary concerning his own profession. "There are 150 doctors in Topeka and 12,000 dead in the cemeteries," he said. "There are 150 lawyers in Topeka and the dockets of the court show 36,000 cases tried and lost. Judging from these facts, our professions are the greatest failures known. But there are 150 doctors and 40,000 healthy, robust people here in Topeka today. There are 150 lawyers and the dockets of the courts show 36,000 cases tried and won."

Dr. L. W. Powell urged his brethren to adopt more business-like methods than the average doctor employs and to send out statements to their patients the first of every month. His subject was "Doctors Bills and other Bills."

Dr. W. J. May of Kansas City spoke on "The Specialist." He said there are now specialists for everything and a man is under their care from the cradle to the grave. Dr. McVey took exception to this in introducing the next speaker and said that the general practitioner is still needed to direct the patients to the proper specialists. Dr. W. S. Lindsay discussed "The General Practitioner." Dr. Lindsay said that a general practitioner in these days of specialists is limited to the head, trunk and extremities.

Dr. John H. Outland finished his stunt as the Roman gladiator at the Elks' show in time to arrive for the close of the program and to respond to his subject, "The Future of the Shawnee County Medical Society."

Previous to the banquet proper a business meeting was held, at which Dr. W. C. McDonough was elected president of the society; vice-president, Dr. D. E. Esterly; secretary, Dr. C. E. Judd, and treasurer, Dr. W. A. Wehe.

Board of Censors: W. E. McVey, 3 years; W. S. Lindsay, 2 years; C. A. McGuire, 1 year.

Washington County: Program of second annual meeting:

Wednesday, December 19, 2. p. m., at Hotel Washington:

Paper—"Some Thoughts Relative to Otitis Media"—Dr. H. L. Alkire, Topeka.

Paper—"Nervousness, Its Significance and Treatment."—Dr. John Punton, Kansas City, Mo.

Paper—"Diseases of the Cervix"—Dr. John Outland, Topeka.

Paper—"Extra Uterine Pregnancy"—Dr. Chas. M. Stemen, Kansas City, Kansas.

General Business and Election of Officers.

Banquet.

Toastmaster—Dr. H. D. Smith.

Toast, "Our Profession,"—Dr. Robert Algie.

Toast, "Medical Organization,"—Dr. H. L. Alkire.

Toast, "The Doctor,"—Samuel Clarke.

Toast, "Doctors' Dreams and Hopes,"—Dr. J. C. Rudolph.

OFFICERS: Dr. M. N. Gardner, President; Dr. R. A. Williams;

Vice-President; Dr. Geo. E. Tooley, Secretary; Dr. W. S. Runkle, Treasurer.

Decatur and Norton County Medical Association met at Clayton, Kansas, Wednesday, December 12, 1906, at S. C. Stannard's office, 2:15 p. m. with this program:

1. Election of officers.
2. Fractures and Dislocation at the Elbow. Case Report,—H. O. Hardesty.
3. Pneumonia.—S. C. Standard.
4. Case Reports and Round Table Discussions—C. S. KENNEY, Sec.

Clay County: Meeting of December 12:

“Rheumatism”—Dr. S. E. Reynolds, Clay Center.

“Typhoid Fever,”—Dr. G. H. Litzinger, Riley.

“President's Address,”—Dr. R. J. Morton, Green.

The Labette County Medical Society met in the City hall council chamber, Wednesday, November 21, for its regular monthly meeting.

The program was as follows:

1. Report of a case of aestivo-autumnal malarial developing in Parsons, with the demonstration of blood-smears showing parasites.
2. Empyema—Dr. C. F. Brody.
3. “Elements of Success in Surgery”—Dr. E. E. Liggett.

The papers were discussed by the doctors in an informal way.

O. S. HUBBARD,

Acting Secretary.

NEWS AND NOTES.

Cystogen costs \$1.00 an ounce. Hexamethylamin, which is the same thing, costs 17 cents an ounce or \$1.75 a pound! This is made by Mallinckrodt of St. Louis. Merck has the same thing, only he calls it “formin” for the same price as the latter. Urotropin is a German preparation of the same thing. It makes quite a difference whether we use the trade or copyrighted name in our prescriptions, or the pharmacopeial name. At least our patients will appreciate the 83 cents of difference.

Phenacetin is another case in point. As acetphenetidin it costs one-third what it costs when purchased of the holders of the copyrighted trade name.

Shall we Teach Anatomy in the High School? The question as to what is the best preparation for the study of medicine is brought to the family doctor. Therefore we all ought to think about it and discuss

it in our society meetings. According to our opinion the usual mistake is to prescribe too narrow courses and set the boy at work at the special sciences while as yet he does not know his mother tongue, mathematics or history. In other words, we believe in a broad foundation and that the candidate for medical matriculation should put in at the high school four years in the study of English, mathematics, Latin, history, some simple science, and French or German. Then in college he should take up botany, biology, chemistry and physics. He must not specialize too early. The teaching, however, of elementary anatomy and physiology in the high school to those pupils who go no farther, is on the other hand advisable and we are glad to see a text on experimental physiology and anatomy brought out by Walter Hollis Eddy.* This book contains some 72 exercises, starting with glass cutting and bending, passing through a study of the properties of foodstuffs, taking up the physiology of digestion and working out even a dissection of a sheep brain. The exercises are written on the inductive basis and quite after the present day manner. Now the value of this work will depend almost entirely on the teacher. If the teacher be a physician who realizes fully what the growing generation should be taught, well and good. But if the teacher know no more than this book teaches and if the teacher be a simple scientist—interested in science for science's sake—then we should greatly prefer that our children get their training in scientific observation and reasoning from some other science,—it would do less damage.

The Coming Legislature must pass on the request of our state university for increased appropriations. This interests us physicians because many of us are sending there our sons and daughters, and we wish them to have as good instructors and as good laboratories as they would have if they went to New York or Chicago. Furthermore, we are interested in the development of our state school of medicine. We hope that the effort on the part of a few men who failed to secure "jobs" will fail to interest our legislators. In this connection the following statistics are of interest:

The combined cost to the state of the state university and state agricultural college is very small when compared with the cost in other states having these institutions separate:

	Ag'l.		
	University.	College	Total
Iowa.....	\$440,406	\$538,000	\$978,406
Michigan	802,975	179,184	982,159
Kansas.....	314,000	212,000	526,000

The handicap under which the University of Kansas is working is well shown by

***Experimental Physiology and Anatomy** for high schools by Walter H. Eddy, Chairman of the department of biology in the High School of Commerce, New York City. Boards, 12 mo., pp. 112; interleaved, text illustrations. New York: 1906; AMERICAN BOOK COMPANY.

the following table. Annual income from all sources including appropriations for building:

	Total	
	Income from all sources	General Maintenance
Kansas *	\$ 314,000	\$250,000
Nebraska	472,477	431,000
Missouri	540,000	473,000
Iowa *	440,406	363,245
Minnesota	850,000	500,000
Ohio	527,401	460,000
California	905,755	855,000
Wisconsin	1,016,000	916,400
Michigan	802,975	742,250

*Agricultural Colleges separate in these states.

The reason why the University of Kansas is falling behind in building equipment is well shown by the following table of buildings erected during the present biennium at various institutions:

Kansas	1
Missouri	4
Nebraska	2
Iowa	2
Minnesota	4
Ohio	5
California	2
Wisconsin	4
Michigan	3

A Request: President Medical College, Kansas City, Dear Sir: here in this town a friend of mine, a Mexican physician, wishes an American Diploma & his willing to pay one hundred dollars will you kindly supply him with one every thing is confidential You can communicate with him personaly & if you say you will he will send you a p. o. o. for amount Yours truly——D. D. S.

The only comment we have is that these Mexicans must have heard of diploma mills in this vicinity.

President Faunce of Brown university says: "We have always insisted that the practice of medicine is a profession and not a trade. Trade is occupation for a livelihood; profession is occupation for service of the world. Trade is occupation for joy in the result; profession is occupation for joy in the process. Trade is occupation where anyone may enter; profession is occupation where those who are prepared may enter. Trade is occupation taken up temporarily, until something better offers; profession is occupation with which one is identified for life. Trade makes one the rival of every other one in the trade; profession makes one the co-operator with his colleagues. Trade knows only the ethics of success; profession is bound by the lasting ties of sacred honor."

The Clay Center Hospital graduated four nurses on December 1. Elaborate exercises were held in the First Presbyterian church of Clay Center, with talks from the minister, the Rev. R. E. L. Jarvis, Dr. M. C. Porter, and Superintendent G. K. Bohring. We congratulate Clay Center on its hospital and the physicians of that town on their enterprise. But no remarks on the subject would be complete without a tribute to Mrs. Bohring, whose fidelity and energy has made the hospital what it is.

The Iola Hospital: The members of the Allen County Medical Society are to be congratulated on the energy with which they have prosecuted the work of erecting a hospital at Iola. They have succeeded also in uniting the profession in that town, so that to our mind they have thoroughly justified their existence. Nevertheless, the harmony of the profession in the town is not without its discordant note; for, a man by the name of J. S. Sutcliffe, who practised in the town for a year without a license altho' admitted by the society into close fellowship in all its enterprises; finally abused the confidence of the society and violated all ethics by advertising, by soliciting patients, and by instigating damage suits. This man claimed in the public press that he was practically the founder of the hospital and the president of its staff; whereas, as a matter of fact, he had not fulfilled any of his promises to provide equipment for the hospital; and on the other hand, had violated his promises not to seek precedence over any other physician in the county. Like all men of his class, he used the public press very freely to exploit his own work and views, with the result that it became necessary for the medical society to publish its side of the controversy and it did so in the issue of the Iola Daily Register for November 29. This article, written by Dr. J. W. Bolton and carefully edited by a special committee, gave a dispassionate history of the entire movement for a hospital, with copies of the original documents, and stated the iniquity of the man so forcefully, that if "Dr." Sutcliffe is not squelched, he is immune to squelching. We congratulate the Allen County Medical Society on the spirit shown by its members and we urge them to keep on in their efforts to advance the best interests of medicine and surgery within their jurisdiction. They need the support of their colleagues throughout the state and we bespeak it for them.

Once before, in dealing with the fakir, Larsen, the Allen County Society carried the matter into the justice's court,—but were defeated. They were preparing to take the matter into the district court, when Larsen left town, Hence they do not feel like taking their controversy with Dr. Sutcliffe to the courts. However, if they should do so, and

should take it to the district court, where careful consideration could be obtained, they would probably succeed. At least, Dr. Haggart's experience at Ottawa leads us to this conclusion. In view of these facts, our Iowa brethren are instituting a campaign of education, by having out of town colleagues address the public, and by using the public press.

Nebraska's Message: The following is being sent to every registered physician in Nebraska who is not in the Society.

DEAR DOCTOR:—

There are in the State of Nebraska today about 1700 physicians, of whom 700 belong to the Nebraska State Medical Association, and many more should belong. Before the next annual meeting in May, 1907, we hope to have a membership of at least one thousand.

This is a day of organization. All classes of people realize this, and nearly all act upon it. The medical profession, less assertive than others, has not become so closely organized as it should be. No deputies are commissioned to solicit membership for medical societies. Though they need it the least, the most advanced men in the profession are the most interested in medical society work. Time and money spent in membership and attendance at medical meetings, is well spent,—not lost. Almost without exception, physicians ally themselves with local orders, as the Masons, Odd Fellows, pay from \$15.00 to \$30.00 initiation fees, and, perhaps, \$5.00 annual dues, mostly to be "good fellows." Good enough, but how much more important to his own, his family's and his patient's welfare to join the County and State Medical Associations which concern his profession,—his life work; and at an expense of \$3.00 for membership and annual dues, for both County and State Associations. Surely a physician's life work interests him to the extent of \$3.00 annually.

What a physician may reasonably expect to gain by membership in an association of his professional brethren is largely self evident and needs but to be hinted at here. During the last few years at least fifteen state Associations have established and now own Association Journals, controlling the advertising pages thereof. Some state associations, notably the Michigan, Illinois and Pennsylvania, furnish for their members, medical defense in malpractice suits. A State Fee Bill, the work of a united profession is a great desideratum. The fact that medical society membership gives physicians prestige with insurance concerns is not sufficiently appreciated by many. But why expand?

Of the method of organization only this can here be said:—The County society is a component part of the State Association, much as the county convention is a part of the state convention, and is represented in the larger body by delegates. A physician who joins the County Society by that act becomes a member of the State Association, and in no other way may membership in the State Association be gained.

I am told you are not a member of the County and State Associations,—if not, why not? Let me adjure you to join the County Society at once if there be one; if none, organize one, and become a part of us, remembering that in union is strength.

Fraternally,

F. H. LONG,

President, Nebraska State Medical Association

Oklahoma: For the enlargement and betterment of the Oklahoma Medical News-Journal. Beginning with the January 1907 issue, the

Oklahoma Medical News-Journal will have a new editor, Y. E. Colville, B. S., M. D., of Chattanooga, Tenn. Dr. Colville has bought a half interest in the Journal and will devote his entire time to the editorial department, while Dr. Phelan will be the business manager. In this way the Journal will be greatly benefited and enlarged, and will be much more valuable to the profession than heretofore.

L. W. Bremerman, A. M., M. D., of New York City, has been appointed Professor of Genito-Urinary Diseases in the New York School of Clinical Medicine, to fill vacancy caused by the death of William K. Otis.

Wanted—The clinical department of the School of Medicine of the university of Kansas, needs the following journals to complete its file. Contributions and offers should be addressed to Dr. Siever, corner of Broad and College streets, Rosedale, Kansas:

Medical Record—Vol. 54, No. 9; Vol. 62, No. 18; Vol. 56, No. 15, 21, 22, 23, 24, 25; Vol. 55, No. 22, 23, 24, 26.

New York Medical Journal—Vol. 76, No. 20; Vol. 75, No. 16, 1, 2, 3, 4, 5, 6, 7, 8; Vol. 83, No. 10; Vol. 84, No. 1, 2, 3, 4, 20.

Annals of Surgery—Vol. 40, No. 4; Vol. 17, No. 5; Vol. 42, No. 4; Vol. 34, Nos. 1 and 2; Vol. 35, No. 1; Vol. 36, Nos. 4 and 5; Vol. 13, No. 6.

American Medicine—Vol. 4, No. 16; Vol. 2, Nos. 1, 3, 4, 5, 6, 7, 8, 10, 12.

Journal of A. M. A.—Vol. 37, Nos. 4, 5, 7, 13; Vol. 38, Nos. 7, 8, 16, 20, 17.

Philadelphia Medical Journal—Vol. 7, No. 5; Vol. 8, No. 21.

The Annual Meeting of the Mississippi Valley Medical Association was held at Hot Springs, Ark., November 6, 7, and 8, 1906. The following officers were elected:

President, H. Horace Grant, M. D., Louisville, Ky.

First Vice-President: G. A. Hebert, M. D., Hot Springs, Ark.

Second Vice-President, T. C. Witherspoon, M. D., St. Louis, Mo.

Secretary, Henry Enos Tuley, M. D., re-elected, Louisville, Ky.

Treasurer, S. C. Stanton, M. D., re-elected, Chicago, Ill.

Columbus, O., was selected as the next place of meeting, during October, 1907.

It was voted at this meeting to offer a prize of \$100 to members of the Association for the best essay recording some original research work in the Mississippi Valley. A committee of three was appointed who will formulate rules of the contest, which will be published later.

Notice: At the meeting of the legislative committee it was decided best to ask, through the Journal, that, anyone having suggestions to make for betterment of Medical Law to send same to the secretary of the committee: C. C. Goddard, Leavenworth, Kansas, at their earliest convenience.

The University of Missouri is talking of establishing the last two years of its medical work in Kansas City. It is reported to be attempting to get exclusive control of the clinical facilities of the city hospital thereby putting the University of Kansas medical school at an unfair disadvantage. It is believed that Kansas City will never consent to any arrangement except one giving the School of Medicine of the University of Kansas equal privileges with any other institution. Kansas City is too closely bound to Kansas to do anything else. The University of Kansas would welcome the coming of the University of Missouri to Kansas City, and if it had the power to do so, would not deny equal privileges to a sister institution. It believes in a fair deal all around and has no doubt that the State will support it in this contention.—(From the University Bulletin).

MEMBERS OF THE KANSAS MEDICAL SOCIETY.*

Additions and Corrections to the List Printed in the December Journal.

Allen County.

J. H. Hindman Humboldt

Atchison County.

C. J. Kale, should be J. C. Cole..... Huron

Cherokee County.

G. W. Walker.....	Chetopa	H. P. Mahan.....	"
C. H. Jones.....	Galena	P. J. Hendrickson....	Columbus
J. H. Buckles	Mineral	G. P. Bell.....	Mineral
L. W. Baxter	Columbus		

Labette County.

A. M. Painter..... Parsons

Lincoln County.

W. A. Hulen..... Lincoln W. A. Heltner..... Lincoln

Lyon County.

J. L. Roberts..... Emporia

Miami County.

F. H. Redmond..... Osawatomie

*The list printed in the December Journal was given us by the Secretary and was therefore official.

Morr's County.

L. S. Harvey Iulay

Nemaha County.

A. J. Best Centralia
 H. Brown, Presdt. "
 W. L. Carlyle Sabetha
 J. J. Everhard Seneca
 D. H. Fitzgerald Kelly
 Guy S. Graham Wetmore
 J. W. Graham "
 George Hall Baileyville
 W. A. Haynes Sabetha
 N. Hayes, Sec.-Treas. Seneca
 T. G. Iles "
 J. H. Magill Corning

J. R. Mathews Onida
 J. C. Maxson Corning
 S. Murdock, Jr. Sabetha
 S. Muidock, Sr. "
 Harry Reding. "
 G. W. Shelton Onida
 W. L. Shelton Woodlawn
 Benj. Skinner Wetmore
 Alvin Snyder Seneca
 H. G. Snyder "
 Preston Thompson Corning
 C. R. Townsend Centralia

R. E. Wright Pern

Shawnee County.

CORRECTED LIST.

H. L. Alkire 715 Ks. Ave. Topeka
 Harriett E. Adams 621 Ks. Ave. "
 A. S. Andrews 727 " "
 J. A. Berry 725 " "
 T. C. Biddle " "
 E. M. Brockett 605 " "
 Ida C. Barnes 726 " "
 John A. Crabbe 735 " "
 S. J. Crumbine State House "
 A. W. Carson Richland
 O. P. Davis N. Topeka
 D. E. Esterly 735 Ks. Ave. "
 B. D. Eastman 605 " "
 F. J. Ernest 807 " "
 J. D. Freeman A. T. & S. F. Hosp.
 W. R. Frisbey Silver Lake
 L. Y. Grubbs 603 Ks. Ave., Topeka
 Sara Greenfield 1131 Taylor St. "
 H. B. Hogeboom 513 Ks. Ave. Topeka
 H. H. Hazlett 613 " "
 A. Jeffrey "
 S. A. Johnson 330 Ks. Ave. Topeka
 C. E. Judd 618 " "
 J. M. Jamison 327 " "
 W. E. Jackson 404 " "
 J. P. Kaster Santa Fe Hosp. "
 J. P. Lewis 735 Ks. Ave. "
 W. S. Lindsay 829 " "
 L. H. Munn 513 " "
 J. C. McClintock 1313 Filmore "

W. E. McVey 625 Ks. Ave., Topeka
 R. E. McVey 625 Ks. Ave. "
 C. A. McGuire 622 " "
 R. S. Magee 634 " "
 J. E. Minney " "
 G. J. Mulvano 613 " "
 H. C. Miner N. Topeka
 M. R. Mitchell "
 W. C. McDonough 603 Ks. Ave. "
 T. W. Peers 807 " "
 L. M. Powell 700 " "
 R. S. Plummer N. Topeka
 F. H. Scholle 517 Ks. Ave. "
 J. E. Smith Grantville
 S. G. Stewart 621 Ks. Ave. "
 W. D. Storrs 616 " "
 O. A. Taylor 226 " "
 N. J. Taylor Berryton
 W. A. Wehe 707 Ks. Ave. "
 W. L. Warriner 634 " "
 H. A. Warner Security Bldg. "
 C. B. Van Horn 333 Jackson "
 Geo. M. Minney 634 Ks. Ave. "
 Thos. R. Hatt Topeka
 S. F. Millard Carbondale
 W. W. Yates Topeka
 Robert Stewart "
 C. W. Schwartz "
 J. R. Fay "
 C. W. Stahl Auburn

Shawnee County—Continued.

S. A. Hamel	Topeka	W. L. Schenck	Topeka.
J. H. Outland	"	W. H. Righter	"
J. B. Towers	"	J. C. Bennett	"
W. F. Bowen	"	E. V. Coldren	"

Wilson County.

T. B. Woodward, Neodesha, is dead.

J. H. Allen, Neodesha, is incorrect and name should be struck out.

The Care of Growing Girls.—One of the most responsible tasks of the family physician is to advise parents of girls entering upon their 'teens, as to the diet, mode of life, and hygienic measures best calculated to preserve the health of budding womanhood. In dealing with these cases the practitioner is often called upon to treat the anaemia which in such a large proportion of instances characterizes the unfolding of the growing girl. Full well does the family doctor grasp the meaning of this anaemia, and the vast importance of combating it before it is too late,—before the impoverished condition of the blood of puberty has left its imprint upon the powers of resistance of the adult organism; has done permanent damage to the future woman and the future mother.

Unsuitable diet, an overindulgence in sweets or spices, over-study, lack of fresh air and physical exercise, indulgence in late hours and abandonment to novel reading, to tight lacing, and other abominations of dress, contribute their quota to the causes of anaemia in the growing girl. Each of these factors is, of course, removable by good common-sense advice to parents and by proper exercise of discipline. Still, when the damage has been done, we must assist nature in its generous work of restoration, and here it is that we are obliged to give that sovereign cure of impoverished blood, iron, in such form as may best be suited to these cases.

The question as to what form of iron we should give to produce the best possible effects has been solved by both experimental and clinical researches conducted during the past twenty-five years—ever since Bunge Hamburger and Doyen and experimentally demonstrated the inferiority of inorganic preparations (Moratand Doyen, *Traitede Physiologie*, Paris, Masson 1904, I, 467). Iron, in the anemia of puberty, produces the best effects when given in a form that will stimulate digestion and researches conducted during the past twenty-five years—ever since increase assimilation, i.e., in the form of the peptonate. With it should always be combined that second hematinic which has been shown enhance the value of iron,—manganese,—and the two are best given in the form of the well-known solution, styled 'Pepto-Mangan (Gude).'

With this may be given, in the anemia of growing girls, minute doses of Fowler's Solution, or else equally small doses of strychnia which may be incorporated with Pepto-Mangan as indicated in individual cases.

Pepto-Mangan has a great advantage over other forms of iron medication in that it does not constipate. Girls at puberty, however, are notoriously prone to constipation. Therefore, this should receive proper attention, chiefly in the regulation of diet, including a sufficient amount of fruit, raw and cooked, and of cereals giving a large residue of cellulose.

With this method of treatment many a physician has achieved success which was rewarded tenfold, by the sight of rosy faces and bright eyes.
—Adv.



ACUTE EXFOLIATIVE DERMATITIS (BOGULE)

The Journal

OF

The Kansas Medical Society

Volume VII

February 1, 1907

Number 2

ACUTE EXFOLIATIVE DERMATITIS.*

See insert plate

H. H. BOGLE, M. D.,
Pittsburg, Kansas.

I present a case history of this rare disease, which is synonymous with pityriasis rubra and exfoliative dermatitis neonatorum. The cause is unknown, though supposable causes are infection and tuberculosis.

As its name indicates, we have a characteristic symptom—shedding of the epidermis. The skin peels, or curls up in various sized, thin, papery flakes. It involves the entire body in most cases. In the beginning of the disease, the peeling and shedding does not occur, but after some days it appears. The disease is very intractable. Even if recovery ensues, the disease will most likely play a return engagement at a later date. The case I wish to cite, of baby R—, is as follows:

Grandmother died of tuberculosis of lungs; grandfather healthy; parents both healthy; no history of any antecedent skin disease; no specific history. The child was born in a normal labor. The umbilicus was slow in healing and was somewhat irritated. It was when the infant was about three weeks old that the parents first noticed that the skin around the umbilicus and under the band, was reddened. But not until it was nearly two months old, or after the disease had progressed some four or five weeks, was it thought necessary to consult a physician.

On examination, I found almost the whole body red and the skin peeling. At the flexures, it was parchment-like, with red furrows, almost bleeding. The babe looked as if it had been scalded. The flakes were cast off almost daily, in size from $\frac{1}{4}$ inch to $\frac{3}{4}$ inch in width, and $\frac{1}{2}$ inch to 1 or $1\frac{1}{2}$ inches in length. At times, quite a large area of

*Read by title before the Kansas Medical Society at Topeka, May 7, 8, 9, 1906.

healthy-looking surface would appear; but in a day or two the exfoliation was as bad as before. There was some fever, ranging from 100 degrees to 102 degrees; and a most stubborn diarrhoea developed, the stools ranged from 10 to 20 per day. Later in the disease, the body seemed to be slightly swollen. The kidneys acted fairly well.

As to the diagnosis in this case, it did not present the symptoms of throat trouble, high temperature and general complications of scarlet fever; nor the great itching, papules, vesicles, crusts, or moisture of eczema. It was too red for ichthyosis. It did not have the mortar-like splotches on an indurated base as in psoriasis. Neither did it show papular lesions nor thickened skin, as in Lichen Ruber, and was also more general; nor did it show blebs and bullae as in pemphigus foliaceus.

The treatment, (which was unsatisfactory) was in general aiding digestion, rendering the bowels more aseptic, and general tonics, as iron, arsenic, and strychnia. Pilocarpine and thyroid extract have been recommended, but were not tried in this case. Locally, olive oil, Lassar's paste and the new † diachylon ointment were used. The object of this was the protection of the skin. The patient died at the age of four months, or after about three months' illness.

SKIN GRAFTING*.

H. H. HEYLMUN, M.D.,
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"Tread not upon the flowers while gazing at the stars." This is a time-worn phrase, whose beauty has excited admiration and elicited eloquence in nearly every hamlet in our land. It is not my subject to-night, but the thought it conveys: That while in search of the greater things, the truths that mark epochs in the history of medicine, that are stars in the firmament of the medical science, let us not tread under our feet the little things, the details, the minor procedures, that not only add to the comfort of our patients, but shorten convalescence and effect a more perfect recovery. When asked to contribute something for this discussion, it occurred to me, after looking the ground over, that skin grafting is one of the little flowers that have been overlooked in the general stampede for greater things. So I pluck it and present it to you with a few observations I have been able to make from cases coming under my care.

As you all know, the first successful method of skin grafting was that advocated and practiced with some success by Reverdin. It consisted of pushing small bits of skin into little holes punched into the granula-

†Bismuthi oxidi dr. 1 Acidi oleici, oz 1. Cerae albae, dr. 111. Vaselineae dr. x. olei rosarum q. s

*Read before the Reno County Medical Society.

tions with the sharp end of a probe. This was followed by the Thiersch method, in which the graft, a strip about the width of a finger and as long as practicable was lifted with a razor. The graft consisted, as nearly as possible, of epithelium only, and those grafts which included much of the fibrous layer were found to possess considerably lower vitality. Profiting by this lesson, Lusk attempted skin grafting by utilizing the epithelial layer secured by a blister. He is credited with considerable success, which from experience I hesitate to grant, for in three cases coming under my observation, while in hospital work, in which every possible detail of the procedure was carefully attended to, there was absolute failure in every instance. It seems hardly likely that an irritant so violent as to cause an exudate of serum beneath the horny layer of the skin would leave much vitality in that layer.

My greatest success in skin grafting has been in the use of the Thiersch method with certain minor modifications, which I will give you in the order in which they are reached when handling a case.

First, the surface on which you expect to plant the grafts must be clean and when I say this, I do not mean a sloughing surface that has been irrigated till apparently clean. I mean a surface from which the dressing can be removed at the end of twenty-four hours, and show practically no pus. In my experience, this result is best obtained by the use of several layers of plain gauze wrung out of a carbolized solution and applied to the surface and covered with gutta percha tissue or oiled silk. The next day irrigate with soap and hot water, rinse with plain water and apply dressing of bovine covered with tissue. This I have found useful both as an antiseptic and as a local tissue food. Alternate the carbolized and bovine dressing and every third day, to prevent hypertrophy of the granulations, apply a dry dressing of boric acid straight. If the denudation is the result of trauma, it is best to have the surface clean and ready for grafting in a week or less, as after that the granulations are sufficiently hypertrophied and soggy to lower the vitality, and consequently reduce the probability of the graft adhering. If the surface is of long standing, such as we have in old varicose ulcers, it is necessary to remove the fibrous coating which here develops with either the curette or scalpel, preferably the latter as it leaves a smoother, cleaner surface. Then instead of applying the grafts immediately as many do, I prefer to wait a couple of days. This gives the time for the damaged tissue to be absorbed, for granulations to spring up ready to attack the grafts and for hemorrhage to cease, so there will be no clots interposed between the grafts and the surface. If the case is one that has stood a week or ten days, I usually apply a glycerine dressing the

day before grafting. This relieves any oedema of the granulations and establishes a healthy circulation in the capillaries.

In the operation of the skin grafting, the surface from which the grafts are to be removed, preferably the antero-external surface of the thigh or the deltoid surface of the arm, should be washed with soft cloth and mild soap and water, then rinsed with saline solutions and shaved. No antiseptics, whatever, should be used. The grafts should be removed by an assistant with a sterile razor, and immediately immersed in a warm saline solution, without the graft being displaced from the razor. He then takes another razor, and removes another graft. The operator takes the razor carrying the graft and applying the end of the graft to the denuded surface, holds it in position with a probe while he slowly slips the razor backward, spreading the graft as it goes. These grafts should be kept moist with warm saline solution, and applied so as to leave about $\frac{1}{8}$ of an inch space between them for drainage, and if the grafts are very wide, it is well to follow the plan advocated by Dr. Harrelson of Kansas City, that of punching small holes through the grafts with a harness punch. This allows a free drainage, which is absolutely essential.

If the grafts are placed too far apart, care must be exercised or granulations will develop between them, and overlapping the edge of the epithelial island, prevent its spreading and finally cause it to be absorbed.

As a dressing, there is nothing better than sterilized gutta percha tissue in strips an inch wide, placed like the weather boards on a house care being taken to place the strips at right angles to the long axis of the grafts. By this arrangement when it is necessary to dress the surface, we can begin at the eaves of the house, so to speak, and, by rolling the upper strip from below upward, remove all the strips without disturbing the underlying grafts.

Next to the strips, I apply several layers of plain gauze, moistened in saline solution, and covered with gutta percha tissue. Over this, cotton and a roller bandage as snug as compatible with good circulation. The moist dressing guarantees free drainage and the snug bandage insures close approximation between the grafts and granulating surface, two points absolutely essential to success.

Contrary to the teachings of the best authorities, I have obtained the best result by changing the first dressing at the end of twenty-four hours.

Great care should be exercised in making the first three or four

dressings lest the grafts be displaced. Use warm saline solutions, only, for irrigation, and let it have no force when striking the grafts.

After about four days, I dispense with the strips all together, and if at this time there are any points of granulation that the epithelium seems backward when invading, I touch them with silver nitrate and apply dry dressings.

In most cases of skin grafting, grafts are taken from the patient himself, and as patients that require skin grafting are nearly always cases of lowered vitality, it stands to reason that better results are obtained where the grafts can be secured from healthy, clear-skinned-subjects just reaching maturity.

In my experience, the best results were obtained when the grafts were taken from subjects of the opposite sex. Whether this was a coincident or whether there is a greater affinity existing between elements of the opposite sex than between elements of the same sex, I am unable to say. Whether nature has extended in a lesser degree the affinity existing between the spermatozoon and ovum, which are products of the epithelium, to the epithelium itself, remains to be demonstrated. The success of the above procedure, however, by means of which I applied sixty-one grafts, at one sitting and had the good fortune to have them all adhere, seems to furnish some grounds for such a supposition.

Coeducation was roundly condemned by President G. Stanley Hall, of Clark University, in his paper recently read before the American Academy of Medicine, in Boston. From his profound studies of adolescence, Dr. Hall is entitled to consideration and his opinions will have great weight in the present tendency to separate the sexes in the public schools after 12 years of age. It is quite likely that the vast majority of the medical profession already agree with Dr. Hall though from different motives. His opinion is based upon the fact that the life role of men requires a set of mental characteristics, the opposite of those of women, and that to modify either sex by training it in the atmosphere of the other, is to unfit it for its struggles for existence. A compromise of methods is unsuitable for either. Boys must be trained to greater manliness and girls to greater womanliness, so that each will be able to supplement the other. Coeducation may not produce long-haired men and short-haired women, but its tendency is in that direction.—
Am. Med.

SUPERSTITION IN MEDICINE.

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From time immemorial, man has been superstitious, and has ever been prone to exhibit this weakness in the field of medicine.

The ancient Egyptians were zealous students of medicine, but believed in charms. In addition to drugs they had recourse to dreams, wizards and gifts to their sacred animals. Also certain charms were written on papyrus, which they carried about with them to cure as well as prevent disease.

Their physicians in treating disease were obliged to follow out certain rules laid down in books, and any deviation from this standard meant death to the physician if his patient died. However, in some instances, these restrictions were removed after the third day, when the physician could use his own judgment.

The mixtures these ancients used were nauseous to a high degree. Often patients were obliged to eat raw meat. Such concoctions as blood, beer and milk, were boiled up together and swallowed while hot. Fish gall and the fat, bones and skins of such creatures as bats, crocodiles, vultures and lizards were standard pharmaceutical preparations!

In addition to giving these remedies, it was necessary that the physician discover what particular evil spirit possessed his patient and drive it out or destroy it. To accomplish this feat he must use very great magic.

The Babylonians had no doctors. When a person became ill, he was taken to the public square where it was the duty of the passerby to enquire of him the nature of his malady and give him any advice that might assist in a cure.

The Jews seem to have been less superstitious concerning medicine than any contemporaneous people. There is no mention whatever in the Bible, of the use of charms to cure diseases.

The Greeks and Romans, although accomplishing something of real value in medicine were firm believers in magic.

The Finns were given to the recitation of long incantations to cure disease.

Perhaps the belief in the occult was as great during the Middle Ages as at any time previous. The progress of medicine during this time was greatly impeded because the priesthood would not allow human

bodies to be dissected. They thought it impious to commit such an act on something made in the image of God. However, they were less considerate of live human beings and literally dissected many on the rack and other instruments of torture.

During the reign of Phillip II of Spain, a doctor was sentenced to death because he performed a surgical operation. The king eventually gave him his freedom on agreement that the physician would make a journey to the Holy Land and thus atone for his crime! This the poor doctor did and died there in poverty and exile.

During the 16th century a medical work was translated from the German, entitled, "A most excellent and perfecte homish apothecarye or physike booke for all the grefes and diseases of the bodye." Here is a prescription found in the book: "If the head doth ake so sore by reason of a runnege that he cannot snoffe hys nose, bath hys fete in a depe tub until the knees and give him this medicine...which riseth into his head and dryeth his moyst braynes."

The following treatment is advocated for dizziness: "He may take the braynes of a hogge, and rost the same upon a grede yron and cut slices thereof and lay to the greved parts."

During the 15th and 16th centuries it was thought the carrying of a lion's eye in one's pocket made him bold and a terror to his enemies. Weak eyes were treated by hanging the tongue of a fox about the patient's neck. It was believed a man could be made very talkative by eating the tongues of ducks and such creatures as were given to much babbling. No mention is made of a prescription for making women more talkative, so we must draw our own conclusions!

To stop hemorrhage of the nose, a toad either alive or dead, was applied to the back of the neck. One form of malaria was treated by placing the fourth book of Homer's Iliad under the patient's pillow. Baked toads were put in silken bags and hung around the neck to prevent disease.

This superstition and mysticism was prevalent among physicians as well as laymen. Doctors, however, once and forever, broke away from the occult when in 1628, Wm. Harvey gave to the world his immortal work on the circulation of the blood. Truth had at last come to reign in a department so long in chaos. From Harvey's discovery has come modern scientific physiology. Now we deal with facts elicited from the laboratory. While physicians are no longer superstitious concerning the healing art and science, the same cannot be said of laymen, and otherwise intelligent laymen at that. We laugh, and say, "What a fool, this ancient to wear a dead toad about his neck." We are more refined and wear asafetida! As a matter of fact, the toad would smell

no worse and would be just as efficacious as a prophylactic, as would the asafetida. It was a U. S. senator who said of one of the greatest delusionists of this generation, that "he was being unjustly persecuted by the medical profession."

We wonder how those Egyptians could swallow such nauseous mixtures. But many of the nostrums taken into the stomachs of people at the present time are much more harmful than a mixture of blood and beer. Recently the president of one of our western universities said of a nostrum which has been proved highly injurious to the human system, "It is certainly a great and wonderful remedy."

A man is generally a fool about every business or profession except his own—but it does seem he is a bigger fool about medicine than anything else.

Superstition always has been and is still an impediment to the proper practice of medicine. That physicians are in some measure to blame for this I do not deny. They are sometimes dishonest with the public, but this dishonesty is not altogether wilful on the part of doctors. Let me illustrate by example: A skilful physician is called to a case. He makes a careful examination and informs the friends of the patient that an immediate diagnosis is impossible, that he will treat the case according to symptoms until it is possible to make an accurate diagnosis. This is the best any doctor can do at times and what they would all like to do, but, Presto! Dr. No. 2 is called in and about the first thing he hears while he is making an examination, is the action and fate of Dr. No. 1. Dr. No. 2 has his human weaknesses and proceeds to profit by his brother's mistake, or rather, misfortune. So he looks wise and gives the disease a Latin name as long as a clothes-line, whereupon the family is satisfied and Dr. No. 2 is thought to be very wise. When people learn to allow the doctors to be honest with them they will get different and better advice. Some one has said good advice consists in finding out what man wants you to tell him and advising him accordingly. This is too frequently the case in the practice of medicine. The ever-credulous laymen are spending thousands of dollars each year that are worse than thrown away, for in most instances distinct harm accrues from using the product purchased. There is no greater field for the exercise of common sense than that of medicine. Apropos of the last statement, there are good reasons for optimistic views along this line. The average man will in time learn that the special diseased conditions are the exception and that he can avoid such conditions by the proper observation of physiological laws. Medicine of the future bids fair to be more in the order of prophylaxis than therapeutics. A physician who cures his fellow-men of disease is a great blessing to them,

but he who can prevent mankind from contracting disease is still greater. We become ill because we abuse our bodies and minds. He is wise who exercises self-restraint, bathes regularly and often, uses wholesome food and chews it well, who reads good literature, thinks pure thoughts and cultivates a cheerful disposition toward his fellow man.

THE MAXWELL METHOD OF TREATING INTRA-CAPSULAR FRACTURES OF THE FEMUR.

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The late Dr. T. J. Maxwell of Keokuk, Iowa, deserves full credit as the originator of the plan of treatment which I am about to present. In the bulletin of the Keokuk Medical College, under date of December, 1904, the doctor in the opening paragraph says: "Fracture of the neck of the femur has been the burden of my labor in surgery for thirty-four years; but like poor Cassandra at the Court of Priam, my message has met with unbelief or indifference until recently good strong men have accepted it and verified the truth and successful results by practice. I contribute this as a boon to thousands of old persons past fifty, who may and will be rescued from invalidism. These persons, mostly old ladies, appeal to us for better treatment than surgery has offered to us in the past. We speak confidently for what we offer, as we have nearly one hundred successful cases to substantiate our contention." Intra-capsular fractures of the femur, as the name implies, are fractures occurring across the neck of the femur and lying wholly within the capsule, whether or not the fracture is wholly within or partly within and partly extra-capsular is of little moment and a question quite impossible to surely diagnose. These fractures occur most frequently in elderly people and the female is more liable in the ratio of about two to one. This fracture is produced as a rule from very slight causes, a fall upon the hip, a trip in a fold of carpet, and cases have been recorded as happening from turning in bed. Sir Astley Cooper claimed the most frequent cause in London was stepping or slipping off the edge of the sidewalk on to the horse pavement, thereby bringing the

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weight of the body in a perpendicular direction upon the neck of the bone. Few cases occur before the age of fifty years; the neck of the bone as age advances, undergoes remarkable changes; the shape changes the size alters and structure is modified. In shape the head and neck become more horizontal forming more nearly a right angle with the shaft; especially is this true in women. The neck becomes somewhat atrophied and in structure more fragile by the absorption of the animal matter of the bone, the spongy tissue cells becoming more rarified and filled with fat.

The symptoms of intra-capsular fracture will depend upon whether or not the fracture is complete or as in some cases impacted. In the latter if by a direct blow upon the hip the parts are forcibly driven into each other, there may be very little deformity with practically no shortening and in any case where a fracture is feared the patient should be completely anesthetized before any amount of manipulation is done. Where the fracture is complete there is shortening, increased mobility, utter helplessness of the affected limb, with marked eversion of the foot; the hip is less prominent than its fellow, the great trochanter will be found to lie posterior to the one of the opposite side and hugging closely the acetabulum. In impacted fractures there may be inversion or eversion owing to the part of the neck impacted. Whichever condition obtains, the leg cannot be rotated to produce an eversion in case of inversion or vice-versa without breaking up the impaction and for this reason the limb should always be handled gently and where possible under an anesthetic. The causes producing the deformity are well-known only the lower fragment is acted upon by the displacing forces. Those strong muscles which are attached about the trochanters and upper shaft pull the lower fragment upward causing shortening, rotating the limb externally causing eversion and strong adduction which flattens the hip.

What is the teaching of modern surgical writers with reference to the prognosis and results of intra-capsular fracture? I quote from Scudder on Fractures, page 268:

"In the very feeble and aged, the shock of a fracture of the neck of the femur is severe. The danger to life in these cases is great. An elderly patient may die of shock within two or three days or within a week of hypostatic pneumonia or he may live several weeks and die of exhaustion because of pain and the enforced confinement. If the fracture can be treated with proper immobilization, union will occur in most cases. The impacted cases will unite; the unimpacted cases may unite." "Of especial value in this connection are the conditions existing in sixteen cases of fracture of the hip, many years after the accident. These sixteen cases were treated at the Massachusetts General Hospital by gentle traction and immobilization, for periods varying from a few weeks to a few months. The patients then went about with crutches. No other treatment was used. Nearly all the cases were unimpacted either primarily or secondarily. At the time of the accident seven cases were between forty-two and forty-seven

years old, the remainder—with two exceptions, whose ages are not stated—were over fifty; three were over sixty years old. These cases reported for examination from two and one-half to twenty-four and one-half years after the accident. Thirteen of the cases have impairment of the functional usefulness of the leg; a weakness of the limb necessitates a crutch in many instances; all movements at the hip somewhat restricted; atrophy of the muscles of the thigh, buttock and calf of the leg; a decided limp, requiring a cane; pain in the hip extending down the thigh even to the sole of the foot; pain in the hip at night; pain in going upstairs and stooping over. In only two cases out of the sixteen could it be said that the leg was functionally useful."

If this is the most favorable prognosis and result which modern surgery can offer, the case is indeed a gloomy one, and one which in the light of the brilliant achievements in other fields of surgery ought not to be satisfactory so long as there is any possibility for better results. I do not share in the opinion that such results are necessary; I believe that too much stress has been laid by surgical writers upon degeneracy of bone and lack of vital energy and not enough upon failure in bringing and holding the fragments in coaptation.

As stated before, the displacing forces are upward, external rotation and adduction. Then certainly the treatment following out the cardinal principles upon which every fracture is reduced and held, if properly treated, is that of overcoming the displacing forces, thus bringing the parts into apposition and by proper appliances hold them in such position. We maintain that the treatment of intra-capsular fractures as advocated by the latest writers, by means of extension and counter-extension in a longitudinal direction only, does not fulfill the demands of the case, to-wit; that of overcoming the displacing forces.

In detailing the treatment, I will use when I deem it necessary, the author's own words without giving further credit than this acknowledgment. For a bed, one should select a good firm mattress; the foot of the bed on the fractured side is elevated twelve inches and on the sound side eight inches. The head of the bed on the fractured side elevate four inches, the fourth leg resting on the floor. This arrangement provides for the counter-extension, the body acting as the weight. This preparation finished, the patient should be carefully laid upon the back with as little disturbance as possible to the fractured joint. The extension of the limb is accomplished by three strips of adhesive plaster, about two inches wide, placed on either side of the thigh on the outer and inner aspects, reaching from the knee well up to the body line, each set of three radiating from a common point at the knee, diverging somewhat as they pass up the thigh; by passing circular strips about the thigh at about the upper, middle and lower thirds, these longitudinal strips will be fastened and will hold all the extension necessary to bring the fragments in proper position. To the lower end of these strips sew a double thickness of heavy muslin, each band of muslin being long enough to reach from the

knee to two or three inches beyond the heel; at the lower end of the muslin strips fasten a block of wood, wide enough to prevent pressure of the muslin on the ankles. A hole bored through the block will give passage to a cord for attaching extension weight, running it over a pulley at the foot of the bed. Apply a roller bandage over the foot and leg, upon reaching the knee passing the roller over the extension strip of adhesive plaster, attached to the thigh. Bend a piece of binder's-board splint around the inner aspect of the thigh, well up in the groin and fasten it with the roller about the thigh. This binder's board is to prevent cutting into the thigh of the next appliance—the lateral extension—that which Dr. Maxwell calls the "sine qua non" of this special treatment. This is accomplished by surgeons adhesive plaster. A strip three inches wide and long enough to go around the thigh close to the body applied over the binder's board and bandage. To the ends of this adhesive plaster on the outer aspect of the thigh is attached a strong muslin bandage which in turn is fixed to a strong cord, the latter carried over a pulley at the side of the bed. This pulley is placed opposite the crest of the ilium, eighteen to twenty inches above the mattress, so that when the weight is applied, the pull will be as the body lies, upward and outward. Having completed this preparation, we are now ready to attach weights which shall hold the injured limb in proper extension. First using longitudinal extension by making steady traction until the injured leg is just as long as its fellow; then to the cord over the pulley at the foot of the bed, attach sufficient weight to hold the leg to this extension, the requisite weight varying from fifteen to twenty-five pounds according to muscularity. To the lateral extension make traction sufficient to bring the hip to equal prominence of its fellow and hold by weight, which will require from ten to twenty pounds. Internal rotation may be accomplished by traction on the strip of adhesive plaster passing under the thigh. The relief from pain will often be found to be almost immediate after the lateral extension is applied. The extension should be inspected daily. Part of the weight may be removed at the end of the first week after the irritability of the muscles has been overcome. The danger of bed-sores is obviated by raising the patient into a sitting posture every third day and rubbing the skin with alcohol. This may be done with no danger of disturbing the fracture. The time necessary to keep the patient in bed will vary from six to ten weeks.

The first case Dr. Maxwell reported occurred in 1871, woman, age 52 years.—Results—no shortening, apparently bony union, at least a useful leg, which allowed the woman to perform the household duties of a farmer's wife for twenty years.

The second case happened in 1881, male, age 72 years. Result—no

shortening or limp, a useful limb which stood the man in good stead for over twenty years. As to the point of fracture and the fact of bony union in the second case there is no longer a matter of doubt since Dr. Maxwell secured this bone after the death of the man; this bone shows a line of fracture wholly within the capsule, with perfect bony union and said bone was exhibited at the American Medical Association in 1901 at the St. Paul meeting.

The following summary is taken from the report published by the A. M. Assn. 1902, from a paper read by Dr. C. E. Ruth of Keokuk, Iowa, a colleague of Dr. Maxwell's:

“Number of cases reported, forty. No demonstratable shortening sixteen; one half-inch or less shortening, eleven; over one-half and less than one inch, ten; flail limb, no union and treatment abandoned in a few days, three; total forty. Age—over 80 years, nine; union with ability to walk well, five; no union, two; paralysis with debility from great age preventing walking, two; from 70 to 80 years, eight; non-union, none; good serviceable union, six; died of brain softening, one; union less than two months' old, quarter-inch shortening, one—total eight. From 60 to 70 years, eight; non-union, none; good, serviceable limbs, eight; no failures to secure union under 80 years of age. No failures to secure serviceable limbs in any case under seventy years of age.”

Doctor A. J. Ochsner, of Chicago, than whom there are few, if any, better surgeons in this country, in the *Annals of Surgery* for October, 1904, reports sixteen cases of intra-capsular fractures, treated according to Dr. Maxwell's method with the following results: Age of these patients ranged thirty up to eighty years of age; all but five exceeded fifty-three years. Results: Two died, one of diabetic coma, and one of exhaustion; good union took place in the other fourteen cases and in none was there as much as three centimeters of shortening. Surely this array of testimony, including as it does fifty-six cases, ought to be sufficient to convince the most skeptical.

Against the successful issue of these cases, I would place by way of contrast the sixteen cases as reported in “Scudder's on the Treatment of Fractures,” with but two out of the sixteen who secured useful limbs. These cases treated as they were by the most approved methods as taught by present day writers lead me to ask if it is reasonable to cling to the old method when the new is so much better? One case of my own I wish briefly to report:

Mrs. D. age 77 years, living on farm with son and maiden daughter, while walking across the lot fell into a furrow made by a plough (the ground being frozen) found she could not arise. She was carried into the house and a physician sent for. Diagnosis not certain. I was sent for and reached the house about seven hours after the accident. I found patient suffering from considerable shock and great pain lying upon her bed.

Examination under chloroform showed foot everted, shortening about two inches, mobility increased. Diagnosis, intra-capsular fracture.

Applied method as stated above, kept her in bed nine weeks. After a day or so, the patient complained very little of pain. She got up after nine weeks in very good condition. She had been frequently raised to the sitting posture to have her back rubbed with alcohol. Results no appreciable shortening. She used limb with perfect freedom for six years, when she died at the age of 83 years. She sent word to me frequently by her son, that she wished she had broken the other leg too, for the broken one was a much more useful limb than the unbroken one on account of a chronic rheumatism which at times crippled the other limb.

That hip bone is now in the museum of the Keokuk Medical College and shows a plain line of fracture wholly within the capsule with perfect bony union.

I believe that the above cases, fifty-seven in number, which I have cited will bear me out in my declaration that for efficiency in the treatment of intra-capsular fractures the Maxwell method stands out alone as the most rational and most successful yet offered to the profession

THE X-RAY AND ITS USES.*

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Roentgen or X-Rays are generated in a vacuum tube, presenting a form of energy manifested in its action upon certain unstable chemical compounds, in which it produces chemical changes, and on certain salts, in which it produces a brilliant phosphorescence. The mode of transmission of this energy and its nature are matters of some importance, but of great obscurity. The cathode ray, discovered and named by Crooks, plays a very important part in the production of the X-Ray. It is given off from the cathode, strikes the target of the anode, and is there converted into, and sent forth from the tube as the X-Ray. The cathode rays are visible in a low vacuum tube, giving a blue or purple color. They act similarly to the ultra-violet ray and may be focused or deflected.

There are different theories as to the X-Ray. Some claim they consist of a stream of hydrogen corpuscles, negatively charged, moving about 70,000 miles per second, causing molecular bombardment within a Crook's tube. Others say they are longitudinal vibrations. The generally accepted theory is that the rays are thrown off as particles

*Read before the Kansas Medical Society at its meeting in Topeka, May 7, 8, 9, 1906.

from all highly heated and highly electrified bodies. The X-Rays are invisible, and can not be reflected or refracted and act at site of entrance as well as exit.

The method of administration, dose, and application of the ray must vary with the object to be accomplished and the tolerance of the patient. This requires, as a lawyer would say, skill, care and diligence, based upon clinical knowledge and experience, with eternal vigilance an ever present important factor. There seems to be no fixed rule which one may safely follow in all cases, each being a law unto itself. In view of its decided dangers, it is better to act cautiously, keeping upon the side of safety, even at an increased expense to patient for prolonged treatment. It is the experience of the best operators, that cases, as a rule, do better with daily treatment. The time of exposure may vary from two to fifty minutes, according to the condition, reaction and urgency of the case. The patient is carefully protected from the action of the ray with lead, tinfoil, etc., except an area about fifty per cent, larger than the area involved. In mammary cancer, the axilla should always be exposed. A medium or soft tube is preferred for superficial conditions and a high tube for deep seated cases.

The reaction, which is the indication for withholding, or greatly diminishing the strength, consists in a tingling, itching, or burning sensation in the skin, slight erythema, slight turgescence, beginning pigmentation, falling of the hair, or a decided change in its appearance.

The value of the X-Ray as an aid to diagnosis in bone lesions and foreign bodies, needs no mention here. Its use in diagnosis of chest diseases has not received much attention. In several clinics in Europe, an X-Ray examination of the chest is considered as important as the observation of the physical signs.

There is no longer any question regarding the value of the X-Ray in many classes of skin diseases. In lupus vulgaris most brilliant results have been obtained. Of acne, eczema, psoriasis, pruritis, sycosis, mycosis fungoides, senile keratosis, venereal condylomata, thousands of cases have been cured or treated with unusual success. In epithelioma the X-Ray may be classed as a specific cure. The next class of cases most successfully treated is cancer of the breast.

The power of the ray to alleviate the many distressing symptoms, pain, offensive odors, arrest of the progress, destruction and casting off of morbid tissue masses, checking of hemorrhage, with general improvement due to hope born of despair in inoperable cases of malignant disease and our ability to improve otherwise hopeless cases, and in a limited number effect a cure, makes the X-Ray a therapeutic agent,

which should be more generally understood and widely used. The ray seems to exert a selective action on the pathogenic growth, and the process by which it disappears is usually one of drying and shrivelling, rather than of sloughing. The reason for this apparent selective action, while not altogether clear, is probably that the low vitality of the neoplastic tissue as compared with the surrounding healthy tissue, causes it to react more readily than the latter.

In masses which have fallen off following treatment by the X-Ray and have been examined under the microscope, the cancer cells were found destroyed, when before treatment the microscope showed the cells most malignant and the clinical history had been one of rapid growth. The good cosmetic effects, a question of no small consideration, obtained by treatment with the ray is probably due to its stimulating influence upon the tissues. In the treatment of malignant disease, surgery, after being in experimental use for many years, has proven a keen disappointment in thousands of cases, and new operations are being devised, with the earnest advice to send the patients earlier,—never early enough. Yet surgery has its place and if combined with the therapeutic use of the X-Ray, an agent of known power and selective action on the cancer cell a larger percentage of this class of cases will be spared to years of usefulness. Every case operated on for cancer should be subjected to the ray immediately after operation to prevent recurrence and metastasis. The ray also has a field of usefulness in the treatment of malignant disease preliminary to operation, when for any reason it must be delayed. In such cases it would doubtless be possible at times to inhibit the development of the growth and render less dangerous the delay. In exophthalmic goiter, X-radiation has proven very successful. In keloid, the ray gives better results than any other agent and it effects complete disappearance of the growth and its replacement by a smooth white scar. Diffuse keloidal conditions following burns are not so successfully treated. In leukemia, we have in the X-Ray an efficient means of relief and in some cases of apparent cure.

The X-Ray has its dangers as well as uses, and operators should take every precaution to protect themselves against this subtle force. But the experience of the pioneer workers in this field has made it possible to avoid that condition known as X-Ray burn, or other breaking down of healthy tissue from the frequent exposure to the ray.

CHOLECYSTITIS.*

JOHN T. AXTELL, M. D.,
Newton, Kansas.

Cholecystitis is the inflammation of the gall bladder. It may be catarrhal, croupous or suppurative, acute or chronic. It may be associated with cholangitis (or inflammation of the bile ducts). It may tend to obliteration of the gall bladder, to stricture of the gall bladder or of the ducts, to gangrene, to perforation or to fistula. It may or may not result in cholelithiasis (or the formation of gall stones).

It is now almost universally conceded to be an infective disease,—the colon, the typhoid and doubtless many other bacilli being prominent in the list of causative agents. Experiments on animals have shown that aseptic foreign bodies may remain in the gall bladder for an indefinite time without causing inflammation or precipitating the solids of the bile. One observer claims that foreign bodies impregnated with virulent bacteria cause an intense cholecystitis but without calculi. If the bacteria, however, are attenuated calculi will be formed. All agree that stasis of the flow of bile is necessary to cause calculi.

Operations and experiments performed in the last few years have caused us to somewhat modify the older ideas of the bile and its uses. It is probably chiefly excrementitious and like the urine is constantly being formed and cast out—although probably useful in digesting fats it is not necessary. Patients may increase in weight and enjoy perfect health with all the two or three pints of bile secreted in a day poured out on the outside of the body. The bile is but slightly, if at all antiseptic. Investigation shows that the secretion of bile goes on with great regularity and is not influenced materially by diet or by “cholagogues.” Patients as a rule are not more constipated when the bile is drained to the outside (so that it does not enter the intestinal canal,) hence the belief in the laxative effect of bile is mistaken. The bile is nine times more poisonous than the urine, hence the importance of draining the gall bladder. The gall bladder is absent in the horse and in some other animals.

A few years ago we depended on finding biliary colic, jaundice and the discovery of gall stones in the feces to make our diagnosis of gall bladder diseases. We now know that more than half the cases have never had biliary colic or jaundice; and in only a very small percentage are calculi found in the feces. The points more to be depended upon

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are digestive disturbances, a dull pain or weight in the right side, and a point of tenderness on pressure between the ninth costal cartilage on the right side and the umbilicus.

If the patient has had typhoid fever or appendicitis the probability is increased. When there is an enlarged gall bladder it is well to remember that it moves with respiration while the kidneys do not do so. The Roentgen ray is not to be depended upon at all in making diagnosis.

Medical treatment has little or no effect. Probably the drinking of large quantities of water is the best medicinal procedure. Doubtless this is why Carlsbad and all other springs are popular. It is generally conceded that calculi do not form unless there is some stasis of the flow of bile. The object of treatment then is summed up in the word drainage. Cholecystomy accomplishes this with a very little danger and with satisfactory results in most cases. Removal of the lining of the gall bladder is better when the organ is greatly atrophied or badly diseased. The treatment is practically the same whether calculi are present or not. They should be considered only incidental (to be removed if present). Drainage is the great desideratum and the operation should always be for "diseased gall bladder"—not for "gall stones."

DISCUSSION.*

DR. HUGHES: I am simply charmed to hear the doctor's paper with regard to intracapsular fracture. It has been my misfortune to come in contact with a considerable number of cases of malignant disease, and I have referred a dozen cases to the X-ray men, and in only one instance have I seen a recovery from malignant disease, and in that case it was called epithelioma of the nose. I have seen cases benefitted and retarded by the use of the X-ray, but I have seen more than the one cured. I have seen a number of cases of carcinoma cured by the use of the knife. I believe it is a good idea to encourage the use of the X-ray in these cases, but I do not think we should lend our voice to the proposition that cancer or sarcoma is curable by X-ray unless the disease is very superficial.

I believe the doctor advances the most modern and advanced thought on the treatment of cholecystitis. I never yet have found a gall bladder with any quantity of pus in it. Inflammation of the gall bladder does not obliterate the gall bladder at times. Upon making an incision in one patient I was astonished to find there was apparently no gall bladder left. The first case of that kind I ever encountered. In the diagnosis of this condition the doctor omitted to mention or associate pain in the right shoulder; in the vast majority of cases of cholecystitis the pain is noticeable in the right shoulder. As in a former paper which was read yesterday, I agree with the author that stone in the gall bladder is the cause of considerable amount of disturbance. In the average case it does not cause very much disturbance. In one remarkable case occurring in the past two weeks in which the patient had a very large gall stone about the size of a small hen's egg, there was no history of pain in the gall bladder, no history of jaundice, but

[*Some of the gentlemen who took part in the discussion have neglected to return their report of the discussion for publication.—EDITOR.]

complaint of pain in the region of the appendix, and within an hour or two of the time I saw the patient, I operated and removed the appendix which was very slightly affected, and in searching around the abdomen for the disturbance I found a hard mass and brought it to the surface, which proved to be a hard substance in the bowels. On making an incision in the bowels the large stone was removed and the intestine sewed up very quickly and I thought safely, anticipating the recovery. The patient died the same night of sepsis. So with that instance we have a good illustration that very large stones are sometimes found, even more than one stone, without any severe symptoms of disease of the gall bladder whatever. As I say, the doctor's paper is modern and I think up to date in every way, although not in accord with the usual thought on the subject of cholecystitis.

DR. CURRIE, Sterling: I like Dr. Axtell's paper very much. I believe we should look upon gall stones as a disease as a misnomer. Gall stones are only symptoms. There are never gall stones in the gall bladder without an inflammatory process. We may have an inflammatory process with the gall stones or without. If the patient passes gall stones and we find them in the feces, we know he did have them, but we do not know any more than we did before—whether he has any more or not. We have chronic cholecystitis, and it has been brought out very plainly that medicine does no good at all; then the only plan is to drain. If we operate on a case of appendicitis and do not find a concretion in the appendix, it was formerly thought it should not have been operated upon. We know it makes no difference whether there is a concretion in the appendix or not if there is inflammation the right thing to do is to have an operation. The same thing is true in reference to the gall bladder. We know what the result is if we allow an acute attack of appendicitis to occur; we know the danger of an operation then, and the same thing is true of an operation on the gall bladder, if we wait until the secretions form. With this true, of course the mortality rate would be very different to what it would be if we operated earlier.

I liked the paper on the use of the X-ray. One thing I believe we should all keep in mind, that the X-ray will not cure everything. We are putting too much confidence in it I believe. It should not be used on operable cases. Where the cancerous growth is large it should be removed, and the X-ray treatment should follow the removal. If we commence on the operable cases we will be disappointed in our results; but if it is removed surgically and followed by the X-ray treatment I believe we will accomplish results.

DR. LATTA: In relation to the paper on intra capsular fracture, I am not well up on the literature of the subject. It used to be taught that we might find disastrous results from long confinement of elderly persons in bed. I would like to ask the essayist why that element did not produce trouble. Is it safe to ignore it?

DR. BACON: In reply to Dr. Hughes, I will say I believe I made no claim in my paper that the X-ray would cure everything. It is not a "cure all" and it will not cure moribund cases. So far as the deep seated cases are concerned they are not so promising as the superficial ones. I have in mind one case of cancer of the stomach—it had been operated on a number of times, and the tumor was quite as large as my head. That case was sent to the X-ray operator, but there was positively no hope of its ever being cured. I recall a case that was operated on about twelve years ago, and the woman is now under treatment for a recurrence. You can remove the tissue but once and there is nothing more to be done but send the patient to the X-ray operator. Of course time alone will prove the efficacy of the X-ray treatment. While it has proven of undoubted value in many cases and a positive cure in others cases, we cannot tell whether it is permanent or not, but I cannot see why those who have

not taken X-ray treatment are better off to submit to surgery which removes part of the tissue.

Of course it is most successful in the superficial cases. I have in mind a case; there was epithelioma on one side of the face and another right under the eye, which involved the bony structures. Those were put under the microscope and they said they were the same class of cancer, but the general character was not the same and they did not respond to the X-ray in the same way. The one which grew the more rapidly has long ago yielded to the treatment and there is nothing now to show but the slight scar. The other is under process of treatment, and I doubt very much if it will be cured. Why this is I am unable to tell.

The next class of cancer which responds best to the treatment is cancer of the breast. I think it is the custom usually, to advise operation. When these conditions are very much exaggerated it is wise to remove by the knife and then submit the patient to the X-ray treatment. I believe if any X-ray operator would come before you and tell you of some of the cures he has performed, it would meet with incredulity. I remember one cancer of the breast which was four or five inches in diameter, quite a large mass, and it is yielding nicely to the X-ray treatment.

The tumor diminishes in size, the pains decrease, and there is no inconvenience whatever, although there is remaining scar tissue. In superficial cases this drops off; but not in cancer of the breast. In operations there are reported about seventeen per cent of cures and eighty-three per cent that are not cured. In these cases that are cured it is impossible to tell just exactly the character without microscopic examination.

In one case I have in mind, a sarcoma of the neck, the young man was under X-ray treatment for eighteen months and the sarcoma has all disappeared. I saw him about a year after the treatment and he was in very good health.

The X-ray of course has a specific action on the cancer cell; in just what way I am unable to tell, but it evidently destroys the cell. In one case of rapid progress the growth yielded to the X-ray, the tumor fell off en masse, and the microscope declared there was no cancer cell remaining. It is a stimulant to the healthy cell. The X-ray of course, can reach a cell which no human eye can detect. If the surgeon could get all the cancer cells he could cure all these conditions.

Dr. WALKER: In answer to Dr. Latta's question with reference to old people, how is it we keep them in confinement from six to ten weeks without producing any shock, and other sequels such as pneumonia. In the first place that lateral extension applied to intra-capsular fracture relieves almost immediately the pain, so that it takes away the cause of the shock. I do not think the mere fracture of the bone causes the shock, but it is the pain brought about by the constant grinding of the bones brought together.

Again, this plan of treatment I have set forth enables the patient to change posture. You can lift them up into a sitting posture every day if you want to, and you can sponge off the parts and give them rubbings and all those things which help to keep up the vitality, and that accounts for the fact that we can keep these patients in bed as we do with out any great shock or exhaustion.

I have a number of cases in connection with Dr. Maxwell on this line of treatment and I have never seen a case of exhaustion or a case of pneumonia follow this kind of confinement. I have seen it in people of eighty years of age, and the case I reported was seventy-seven years of age, a very large woman, and a case you would think confinement in bed would bring about a great many difficulties; yet in nine weeks she got up from her bed in very good condition physically.

I was glad to know there was one, Dr. Schwartz, who had treated a case after this plan. I would tell the Doctor that it is not a question that is going to die with the au-

thor of this plan of treatment, for I know at the Denver meeting at St. Paul, and again at the meeting in Saratoga it occupied a very important position upon the program of the American Medical Association. It was thoroughly discussed.

It seems the profession have been a long time in seeing the rationality of this treatment. It is the rational treatment. It simply holds the parts in position and the bones will unite.

I am sure that in nearly every town of any size you will find old ladies going around on wheel chairs and on crutches, etc., or with noticeable limps, because of these intracapsular fractures that have not been properly treated.

HYPOPYON KERATITIS.*

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Pittsburg, Kansas.

Hypopyon Keratitis is the name that has been given to the combination of ulcer of the cornea and pus in the anterior chamber. Before going into the causes of inflammation of the cornea, let us take a cursory view of this membrane. The cornea is more exposed to external injuries, than any other portion of the eye ball. It has no blood vessels of its own. Its central zone is quite a distance from the blood vessels, from which it must absorb its nutrition; for this reason when the central zone is injured, or attacked by microbic infection it has less resistance than other portions of the eyeball. In studying the different forms of inflammations of the cornea, I think it best to divide them, into superficial and deep, and I shall place Hypopyon Keratitis, as a subdivision of the deep variety. All inflammations of the cornea are recognized as being of microbic origin, and usually exogenous in type. Microbic infection endogenous in type is very exceptional. The conjunctival sac is supposed to contain infecting microbes all the time, and in greatly increased numbers in those patients that have dacryo-cystitis. The microbes that are usually held responsible, for inflammation in the cornea, are *Staphylococcus aureus*, *staphylococcus albus*, *pneumococcus*, and *streptococcus*. The epithelium presents an insurmountable barrier to these microbes, and it is necessary for it to be abraded, in some way, before they can gain entrance. When they gain entrance into the cornea, they secrete toxins, which diffuse in every direction through the tissues, and upon reaching the periphery of the cornea, paralyze the pericorneal vessels, and exudation of plasma and leucocytes takes place.

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These are drawn by this substance to the point of infection. In this way an infiltration of the corneal tissue is produced. The infiltrated tissue breaks down, and an abscess is formed. The layer covering the abscess breaks away and an ulcer is formed. Some ulcers have a tendency to spread over the corneal surface, others go deep into it. Some are purulent; others, non-purulent. Some attack by preference the margin of the cornea, others the center. Some will yield to treatment readily, others are almost incurable. Again some ulcerative corneal processes are attended by much circum-corneal injection, severe pain in and about the eye, great reflex blepharospasm, and lachrymation, while others, which may really be more severe processes in so far as the integrity of the eye is concerned, can run their course with scarcely any injection of the eyeball, and with little or no distress to the patient (Swanzy). I will not go into the different steps of an inflammation of the cornea, but will say that the struggle against microbic infection is a function of the migratory cells. I account for these different manifestations by the distinctive manner in which each microbe affects the cornea. It was once the opinion of ophthalmologists that fistulous tracts formed, leading from the ulcer into the anterior chamber. Pus found its way through these fistulous tracts into this chamber and in this way they accounted for its presence there. I find the following statement in Juler, "When the abscess is near the surface, the superficial layers of the cornea break down and form a superficial ulcer. When it is deeply situated, the pointing takes place inwards, and the pus passes into the anterior chamber. It occasionally happens that an abscess opens both outwards and inwards, and so forms a fistulous opening into the anterior chamber." From the investigations lately made I am persuaded that this accounting for pus in the anterior chamber is incorrect, from the fact that microbes are not found in the pus, for the membrane of Descemet will not allow a microbe to pass through it. I cannot help at this point but notice the the protection the eye has against microbic infection. The epithelium, the superficial layer of the cornea, presents an insurmountable barrier to the microbes in the conjunctival sac, and when they gain entrance into the cornea through an abrasion in the epithelium, the membrane of Descemet prevents them from gaining entrance into the anterior chamber. I have seen every lamina of the cornea broken down, except the membrane of Descemet, and yet it maintained its integrity, and sustained the intraocular pressure.

Professor Leber accounts for pus in the anterior chamber in the following way: The phlogogenic substances, toxins, produced by pathogenic microbes in deep ulcers of the cornea, diffuse in every direction; if the toxins are sufficiently numerous, they reach the iris,

where they cause the same vascular alteration, exudation of plasma, and emigration of cells,—i. e., iritis. The exudation, especially the cells, may accumulate on the bottom of the anterior chamber under the name of hypopyon.

It is not a difficult matter, to make a diagnosis of hypopyon keratitis, with ulcer in the cornea and pus in the anterior chamber, but sometimes these ulcers will be seen before pus has formed in the anterior chamber. I think it a good plan in the diagnosis of corneal ulcers, to divide them into superficial and deep. The anterior corneal planes, receive their nutrition, in almost the same manner, as the bulbar conjunctiva, while the deeper planes have a nutriment supply, that is more closely allied, to that of the sclera, the iris and the ciliary body (Nuel). We can see from this anatomical arrangement, that diseases that affect the deep corneal planes are likely to affect the iris and ciliary body, so we see the necessity in deciding if the ulcer be superficial or deep. This is sometimes very difficult to determine by mere inspection of the ulcer. In ulcerations of the deeper planes of the cornea, the phlogogenic substance is diffused in every direction and causes a congestion of the iris, so an inspection of this membrane will reveal the gravity of the disease.

The first questions to consider are: Is there a congestion of the iris? Is the pupil sluggish in action? Has the iris lost its beautiful luster and taken on a muddy color? Is there ciliary pain?

Hypopyon keratitis is a very grave disease so far as vision is concerned. This is the disease that produces dense cicatricial tissue, or staphyloma may follow in its wake. In an ulcer we have loss of substance, and in the healing process, this loss must be filled in with connective tissue, and it seems to be a law of nature, for connective tissue to heal in whiter than the original tissue. This should be explained to every patient with ulceration of the cornea that is likely to have cicatricial tissue follow: otherwise, he may think that he has been incorrectly treated. If you will notice, most of the cases of hypopyon will come from the working class, and nine cases out of ten, can be traced to an injury. The ulcer will be centrally located, or lap into the central zone, because it is the most exposed region of the cornea. A dense white opacity called a leucoma will be left. This is why vision is so badly damaged. More dangerous than leucoma is staphyloma. The cornea having been weakened by the deep ulcer, is no longer able to withstand the intraocular pressure, and an anterior staphyloma is formed.

There are many other untoward conditions that are likely to follow, which I shall only mention: Anterior synechia, posterior synechia, (both of these predispose the eye to glaucoma).

In the treatment of hypopyon keratitis, I consider the ulcer the home

of the microbe, and the point from which the plogogenic substances emanate. For this reason I think it necessary to render the ulcer as aseptic as possible. To do this, it is necessary to use an antiseptic, or use the electro-cautery. A deep corneal ulcer, with much infiltration, and pus in anterior chamber, is an indication that the ulcer will rapidly enlarge. The first and imperative thing to do, is to stop the progress of the ulcer, and there is nothing I know of, that will do this so effectually as the electro-cautery. When we burn corneal tissue, cicatricial tissue will follow, the condition we so much dread, but if the progress of the ulcer is not checked, the cicatricial tissue of necessity, will be much more extensive than it would have been, if the cautery had been used. There is a stimulation in this kind of treatment. It usually stops the pain at once, a new action commences in the ulcer, and the whole eye begins to improve. I would not use this line of treatment in every case of hypopyon. I select those that are strongly infected and progressive. I cocaine the eye well, and use only a dull red heat. With a needle at white heat it is easy to destroy more tissue than necessary. Iodine or carbolic acid is good treatment for these ulcers. In using iodine or carbolic acid, it is necessary to dry the ulcer, after having used cocaine, and apply the iodine or carbolic acid to every part, then dry the ulcer again, so there will be none left to run over the cornea. Then wash out the conjunctival sac with a boracic solution. It is necessary to give the interior of the eye some attention. There is always iritis with every case of hypopyon, and it is necessary to dilate the pupil if possible. Atropine sulfate is the best remedy for this purpose, but will do very little good if the anterior chamber is half full of pus, or if there should be posterior synechia, that cannot be broken up. A pressure bandage is always necessary in all cases. The cornea having been weakened by the ulceration, there is great danger of anterior staphyloma. When the natural secretion of the eye is altered by inflammation it may be transformed into a favorable medium for germ life, but in its normal condition the secretion antagonizes bacterial growth. Strong antiseptics diminish the resistance of the eye and render it less likely to ward off germ invasion. For this reason I think the conjunctival sac should be carefully cleansed with a weak solution of bichloride of mercury of 1 to 5000 or 1 to 10,000 and the ulcer touched with a saturated solution of methyl blue or violet, and a solution of atropine to be used four times a day. Hot douches and compresses are often serviceable. For pain phenacetine, or sulphonal, or the tablet of acetanilid and sodium comp. are recommended.

The above treatment will be found very good for the milder cases. I have just finished a case in which there was not a great deal of pus in

anterior chamber, and ulcer did not seem to me to demand the galvanocautery, although it was centrally located; so I cleansed the ulcer with tr. iodine, then washed out the conjunctival sac with a boracic solution. In this case there was a great deal of pain, and I used morphine sulfate hypodermically, but this relieved the pain only for a short time. There was a plustension in this case, and I decided this was the cause of the pain, so I did a paracentesis, not for the purpose of evacuating the pus, but to relieve the tension. The results were all that could be expected, but the small amount of scar tissue left, being centrally located, greatly interferes with vision.

Some recommend the subconjunctival injection of cyanide of mercury. Dr. De Wecker recommends several drops of corrosive sublimate solution of the strength of 1 to 2000 or 1 to 1000 to be injected beneath the conjunctiva after cocainization. Pfluger has shown that substances thus injected really reach the cornea. This line of treatment seems to be founded on rational principles; yet results have been no better than when antiseptics are used in the old way. It is supposed that any change in the normal nutrition of the human tissue, or the deposit of any heterogeneous principle in the tissue, there is produced a phlogogenic substance not unlike that produced by pathogenic microbes (Nuel). So it is possible that injections of strong antiseptic solutions beneath the conjunctiva may have to be taken care of by the migratory cells. While antiseptics will kill microbes, it is not likely they will neutralize the toxins produced by them, so I think the best treatment in cases so severe, as to require the subconjunctival injections, is to use the antiseptic in the ulcer. Iodoform, argyrol, and many other bactericidal remedies have been recommended. So far I have not had any experience with the serum treatment.

Paracentesis will be demanded in many cases. If the chamber is filled to the lower border of the pupil, I think it would be best to do a paracentesis. The phlogogenic substance that poisons the uvea, and causes a collection of pus in anterior chamber, does not always stop with formation of pus in the anterior chamber, but sometimes causes pockets of pus to form in the posterior chamber. This explains why these cases improve so slowly and are benefited by a paracentesis. If the ulcer is very large, the incision of Saemisch may be demanded. The chamber should be emptied as slowly as possible, otherwise, there will be hemorrhage and the patient will experience great pain though the incision may not be felt. It has not been my practice to wash out the anterior chamber with antiseptics, but with normal salt solution. I do a paracentesis with a Von Graefe knife, and I make the incision below the ulcer in the lowest part of the anterior chamber, and in healthy corneal tissue if possible.

DISCUSSION.*

DR. REYNOLDS, Horton, Kan.: I was not paying very strict attention. I was short of sleep last night and I did not hear all the paper. I notice the doctor's reference to the accumulation of what appeared to be pus behind posterior elastic membrane. We have known for a long time that this apparent accumulation does not contain the pus germs, but the corpuscles coming there for some purpose. When you have an actual accumulation of the pus, let it out. There is nothing better than the cautery when properly applied to surface infections.

DR. JAMISON, Wellington: You touched upon the vital point. It has been my experience to have never seen a healthy man with an injury to his cornea that gave me dead leucocytes in the anterior chamber. I think we missed the one point, that there is always want of resistance. If a man is in good health those leucocytes will not die in the anterior chamber.

DR. LONGENECKER: Mr. Chairman, this is a very important subject. It probably causes more blindness in middle life than any other affection of the eye. It seems to be found more frequently in persons at middle or past middle life, and is more prevalent in the fall or spring of the year. In my practice most of the cases have occurred in the fall of the year. The worst cases of hypopyon keratitis usually come from an injury to the cornea, as a bruise or laceration, such as might be inflicted by a branch or twig of a tree, or from the impact of a small gravel or other substance flying into the eye.

In these cases the ulcer seems to spread more rapidly, and before we can bring our remedial measures into activity there is danger of breaking down or sloughing and consequent loss of the eye.

We are obliged to depend upon that conservative process of nature known as inflammation which brings to the neighborhood of this affection the fighting agents of the blood. The pathway to the seat of the trouble lies in the conjunctiva surrounding the cornea. If the injury is in the center of the cornea, the blood vessels of the conjunctiva can do little good unless the inflammation is high enough to force the formation of new blood vessels into the cornea. So we welcome the attending inflammation around the cornea. The treatment given by the doctor in his paper is all right. I have no criticism to offer.

The accumulated exudate in the anterior chamber is a different character from the purulent discharge found in the ulcer on the surface in the cornea. If it were of the same character we would in all probability have rapid destruction of the eye.

The question of early paracentesis to evacuate the exudate from the anterior chamber must have to do also with the danger of introducing infection from without. When it becomes necessary though, we must take that risk. It is the only way we have of quickly getting rid of extensive accumulation of exudate within the eye. As has been said in the paper, our main efforts are expended in checking the extension of the ulcer. When the ulcer occurs in the central part of the cornea, remote from the conjunctival blood vessels, it usually spreads very rapidly, and soon affects with infiltrates a wide band of corneal tissue surrounding the ulcer. The cornea at the edge of the ulcer becomes undermined and presents an overhanging edge of corneal tissue. The pockets formed by these overhanging layers of corneal tissue form a splendid place for micro-organisms to accumulate and develop.

To get rid of this devitalized tissue, destroy the germs contained in these pockets,

(The report of this discussion was submitted to every one who participated. All the others neglected or refused to return their copy for publication.—EDITOR.)

and at the same time stimulate the tissues beyond the seat of the ulcer. I know of nothing better than the careful but yet thorough application of the electric cautery.

DR. MAGEE, Topeka: I do not believe we have a paper on the list that is more important than this one which has just been read. The treatment of hypopyon is one with which you have to deal if you have many ulcers of the cornea. As has been well said there is no disease of the eye which destroys more eyes than the ulcer of the cornea. I am inclined to believe that Dr. Reynolds has touched the key note when he questions the diagnosis of this being pus. I am coming to the belief that it is not pus, and only in exceptional cases is it pus. If we have such a thing as sterile pus, if you will allow the use of the name, that is it. I am of the opinion that the anterior chamber ought to be opened in these cases. As has been said by Dr. Longenecker, the danger of infection to the interior of the eye is when you open it. The opening in this case cannot be made sterile. You cannot open such an eye with any degree of safety. The material in there is not doing any harm. I question whether the intra-ocular pressure is sufficient to warrant paracentesis. Just as soon as the ulcerative process has ceased this material will take care of itself. The treatment should be instead of a paracentesis hot moist applications with touching of ulcer with some antiseptic—best indicated by the appearance of the ulcer and general condition of eyeball. This is the plan followed.

DR. DORSEY, Wichita: I just wish to speak about two or three small things in regard to this condition. In the first place I think that ulcers of the cornea should be treated rationally the same as other infected spots. It is a small infected spot. If we could destroy that infection before it is taken far away, we destroy the disease. Personally I have seldom found it necessary to use the electric cautery. Occasionally I consider it the best thing possible, especially where the infection is intense and you do not know the destructive agent with which to combat it. I have frequently used the carbolic acid treatment and it has value. I frequently use nitric acid, after thoroughly cleansing the wound, and found very beneficial effects. By the use of the electric cautery, if one makes the slightest error with the needle he is likely to do great harm.

The second thing is the use of holocaine instead of cocaine. The tendency cocaine has to loosen the epithelium of the cornea makes me prefer holocaine and holocaine has some antiseptic qualities.

In the case that the doctor spoke of in which he performed a paracentesis, without reference to the hypopyon—by this way I would say that most hypopyons will be absorbed if they do not cover more than one-third of the chamber. In the case where he performed the paracentesis I believe he would have found benefit from the use of dionin, together with very hot applications to the eye. These remedies have frequently given very excellent results with regard to the relief of pain.

DR. GSELL, Wichita: Dr. Graves has covered his subject, I think, very thoroughly. I see oculists differ in the use of their cauteries as surgeons differ in their methods. I have been in the past using glacial acetic acid with beneficial results. I have been rather fortunate in treating what few cases of hypopyon I have had. I have never found it necessary to do a paracentesis. I have had several cases in which I was tempted to do a paracentesis but thought I would wait a little longer, and the hypopyon began to clear up. I believe it is necessary of course to at first stop the ulcerative process.

DR. GRAVES (closing) There seems to be a mistake about the exudation of plasma and cells that are found at the bottom of the anterior chamber under the name of hypopyon. The first speaker on the floor said they were there for a purpose. Accord-

ing to the theory of microbe inflammation the pathogenic microbes produce phlogogenic substances, toxines, these are diffused in every direction, and if sufficiently numerous, may reach the pericorneal vessels and anterior chamber, the pericorneal vessels are paralyzed and an exudation of plasma is provoked and an emigration of leucocytes. This exudation is attracted by these substances to the point of infection and thus corneal infiltration is produced, in this case the leucocytes have a function to perform, to stop the progress of the pathogenic microbe.

Now if the substance first mentioned, toxines, reach the iris, the iritic vessels are paralyzed, and an exudation of plasma and leucocytes are produced, but this exudation cannot reach the point of infection as in the case of the pericorneal vessels, and must lodge in the anterior chamber, from the fact the membrane of Descemet presents a barrier through which they cannot pass so I can not see any function this collection in the anterior chamber has to perform. I do not advise paracentesis in all cases for if there is only a small collection it will be absorbed, but experience has taught if the pus has reached the inferior border of the pupil, the resorption of the pus is no longer possible. Some one recommended nitric acid with which to cauterize the corneal ulcer. I do not consider nitric acid a safe remedy for you cannot control it as you can the galvano cautery.

GANGRENE OF THE SKIN.

Report of a Case.

E. SMITH, M. D.
Lawrence, Kansas.

Hazel H. act. 19 months. First seen in the early morning of July 13, 1906. She had vomited and had fever during the night, and a convulsion just before I was called; when seen her temperature was 105 degrees in the axilla; after this it varied from nearly normal to 103 degrees. About one hour later a diarrhoea set in, with at first copious discharges, followed by evening with severe tenesmus. The tenesmus continued to the end, with slight remissions. There was no blood in the stools. On the morning of the 14th, the mother called my attention to a small blister on the right natis, it was filled with clear serum. It spread rapidly until it covered the right buttock, and extended to the left of the anus; at first the part looked like a red scald, later becoming livid in the center, the livid part growing darker and spreading.

On the morning of the 15th, four blisters came on the back, and one on the thumb of the right hand. The one on the thumb had extended by the next morning, so as to cover the whole hand, and about one fourth of the forearm. The hand was swollen, and the palmar surface was livid. Those on the back spread until they covered a third of the dorsal surface.

At about 11:30 a. m. of the 16th, she again vomited and rapidly failed, and died about 2 p. m.

A PLEA FOR CONSERVATISM IN SURGERY: A NEW METHOD AND A PROPOSED NEW INSTRUMENT FOR TREATING RETROFLEXIONS : REPOSITION AND PACKING.

FRANCES A. HARPER, M. D.

Pittsburg, Kansas.

It has been said that "there is no new thing under the sun." Accepting this statement as true, my only apology or explanation for introducing anything "new" is as follows: I believe that we are too prone to look upon the study of medicine as purely a science,—simply "ascertained truths and facts," instead of making of it an art as well by "the application of knowledge or power to practical purposes." I claim no particular originality in my methods of treatment, excepting in the following out of certain lines or channels which have been indicated or suggested to my mind as being productive of good results in cases heretofore unbenefited by any line of local or medical treatment; lines which have not, to my knowledge, been fully followed out, and which my "inquisitive bump" has led me to investigate for myself; and in the

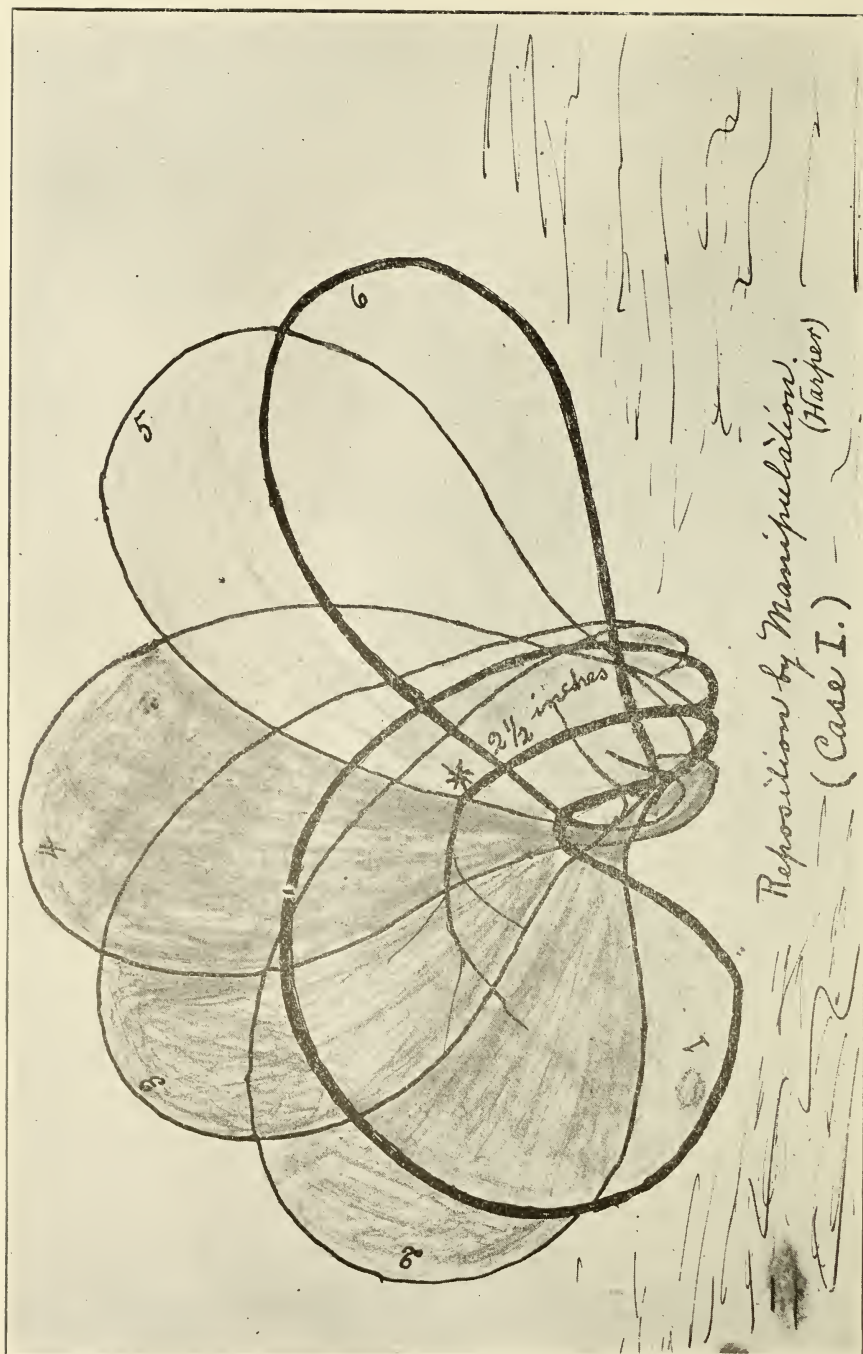
EXPLANATION OF PLATES.

Plate I. Reposition by manipulation, showing position of uterus in various stages of the process. This was a case of extreme retroflexion with adhesions to rectum, which were broken up only after a month of persistent treatment and manipulation. Cut shows results of seven months of treatment.

Plate II. Principle of Packing for Support. Fig. 1 represents case of simple retroversion. Uterus is made to describe a half circle, and carried over to normal. Figs 2 and 3 illustrate the principle involved in packing for support—the packing serving as "rest" or "brake" as case may be. If displacement is a posterior one, manipulate for reposition by directing force downward upon anterior aspect of cervix, at same time applying a lifting force upwards and forward upon fundus; to hold position gained place cotton roll in anterior fornix. After uterus has passed beyond the mid-point, and is in anteversion, the roll may be placed posterior to cervix. At this stage in many cases the double roll seems to give much satisfaction, and serves as a firm "pessary," holding organ well in place.

Plate III. Fig. 1. cotton roll, ("cotton pessary") Fig. 2. Cone shaped cotton wool tampon, for special medication and counter support. Fig. 3: Lamb's wool tampon, used as accessory packing for either medication or support where a specially soft one is desired. Fig. 4. Single-roll "cotton pessary" in situ. Fig. 5. Double-roll "cotton pessary" in situ.

Plate IV.—Faulty but perhaps common method of "plugging" vagina, probably many times aggravating the condition or exaggerating the deformity, instead of overcoming it. (This is a condition very apt to occur following labor from tight bandaging and persistently lying on the back.)

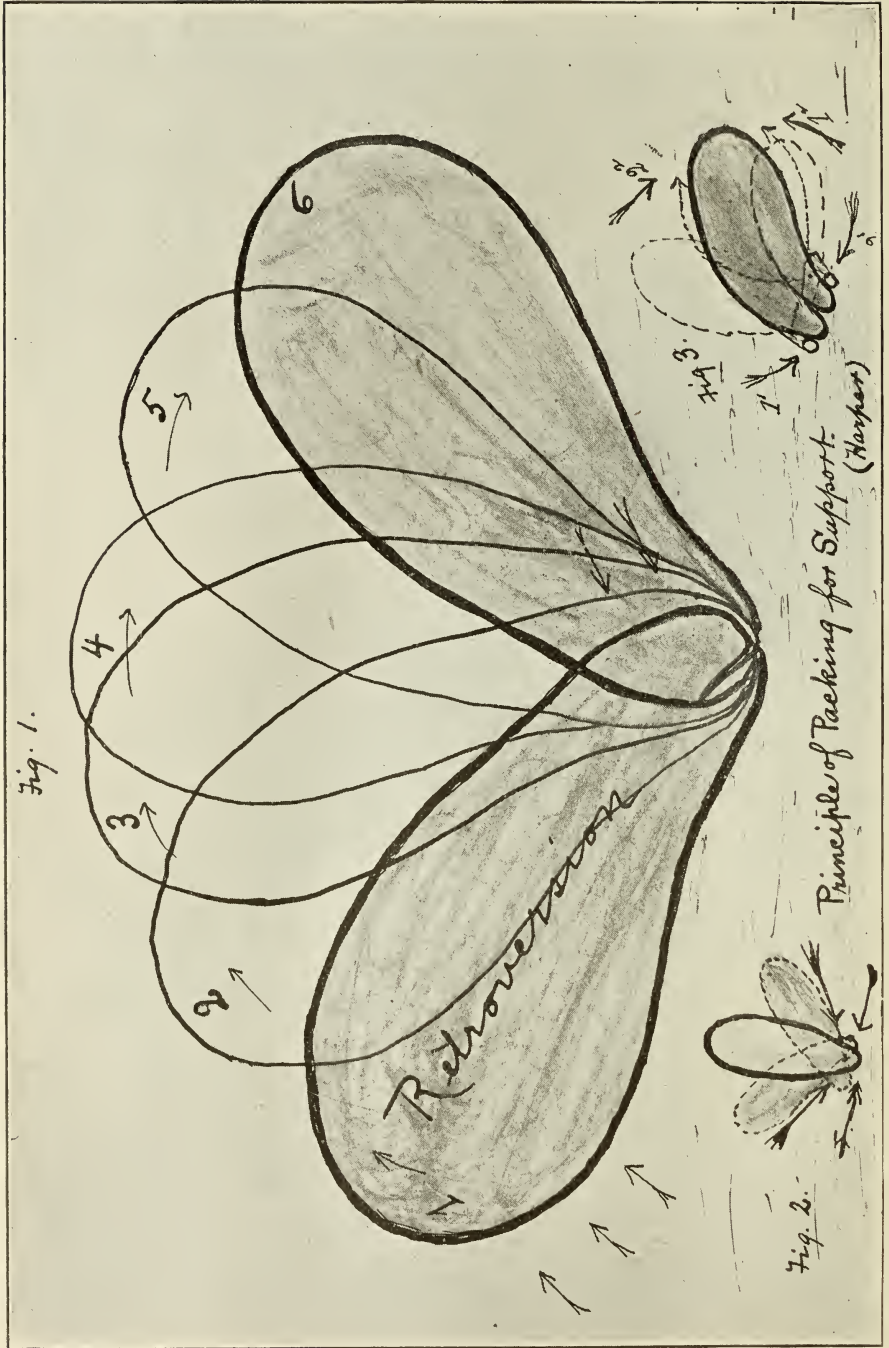


following out of which I have obliged to forge my own tools,—the only direct evidence possess of a comparatively virgin field.

At best, our medical colleges can only give us the key with which to unlock many of the problems which confront us in the medical world, and it must rest largely with ourselves, individually, whether or not we properly apply the key, or if when the storehouse is opened we recognize what is indicated or unfolded before us.

I look upon radical operations, unless definitely indicated, somewhat as I do upon capital punishment. In condemning a man to death, we take that which we cannot by any means restore. "Life imprisonment" however, gives us the opportunity of giving back to the man that of which he has been temporarily deprived, if we find that an injustice has been done. So it is with surgery in the various chronic ailments of women. How many operations are done which end disastrously, or unsatisfactorily, after which the surgeon asks himself,—"Now, if I had done so-and-so,—or had not done so-and-so, might I not have saved or benefited my patient?" And there always remains a vague doubt in his mind as to whether or not he did just the proper thing; perhaps he operated too soon; perhaps not soon enough; perhaps the patient would have been better without operation at all.

Too many in their zeal to "operate" make a hasty examination,—perhaps seeing the patient for the first time,—advise "an immediate operation," of course; "really cannot tell just how bad the condition is," but wishes "the option of removing whatever organs or parts of organs" which in his best judgment he deems necessary for the well-being of the patient. ("Conservative surgery!" how many sins are committed in thy name!). This sounds all right to the patient; perhaps the surgeon means all right; but it looks too much like condemning a man to death on circumstantial evidence without the formality of a trial! As a rule, however, when a woman has gotten up her courage to visit a surgeon for consultation, she rather expects him to advise operation,—and in order not to disappoint her,—he usually does! I do not wish to be understood as doubting the judgment nor the honesty of all surgeons,—for, God bless them! there are among them some of the noblest men the Lord ever made, and some of the greatest benefactors of the race; neither am I crying down all operations, for many cases are really desperate, and desperate remedies are sometimes necessary; but we cannot help but know that there is a certain class of operators who simply look upon an operation from a monetary standpoint, and as adding one more case to their already long list of "brilliant and successful operations,"—if the patient does die! I once heard a story of an eminent oculist who was demonstrating the straightening of an eye before his class. The case



and dexterity with which he performed the operation occasioned general comment. "Ah, boys," quoth the professor, "you'll have to learn by experience. I spoiled a whole hatful of eyes before I learned to do this!"

In studying over this subject, I have scanned the various articles and discussions in the medical journals, in order to catch if possible the meaning conveyed, or intended to be conveyed, by the term, "conservative surgery," and the views held by operators as to its practicability and merit. I find that many who at first favored the idea, have, after duly observing the results of such conservatism, become more and more in favor of radical operations, and less and less in favor of conservative ones. Why is this? Is it not that we are apt to "place the cart before the horse," and practise our conservatism after operation rather than before? The idea which seems to prevail, with some operators at least, is to open up the abdomen, examine the various organs and appendages, diagnose, determine degree of involvement, treat or excise such organs or parts as are deemed necessary or advisable at the time, —close wound, with idea of perhaps following later with a "secondary" operation. (I recently heard of a case which had been operated upon seven times for the same trouble, and an eighth operation was contemplated! This is as bad as the woman who was subjected to ovariotomy five times, and the man who had his appendix removed three times!) Exploratory incisions are sometimes necessary to clear up doubtful diagnoses, but altogether too many "exploratory incisions" as well as experimental excisions, are made for the purpose of diagnosis, which would better have been made by external observation and treatment, —following later with operation, if necessary, after the subsidence of many obscure and misleading symptoms; then go in with some well defined purpose in view.

Conservative surgery is defined as "**surgery which looks to the preservation or restoration of disabled parts, rather than their removal.**" Broadly speaking, it means that we should **use** and **exhaust** every rational means in our power to restore a part; failing with these, we call to our aid surgical means to do what in our best judgment and reasoning non-surgical measures will not do, — **cannot do**. This makes of a radical operation a conservative one. This is true conservatism in surgery, or "conservative surgery," as I understand it.

The full blame, however, for too many and too radical operations cannot wholly be laid at the door of the surgeon, for oftentimes he must take our diagnoses and comes to our rescue in cases which we as general medical practitioners have ineffectually and indifferently treated for months, and perhaps years. Are we wholly blameless, if operation fails? Did we **exhaust** every known means to relieve or to cure our pa-

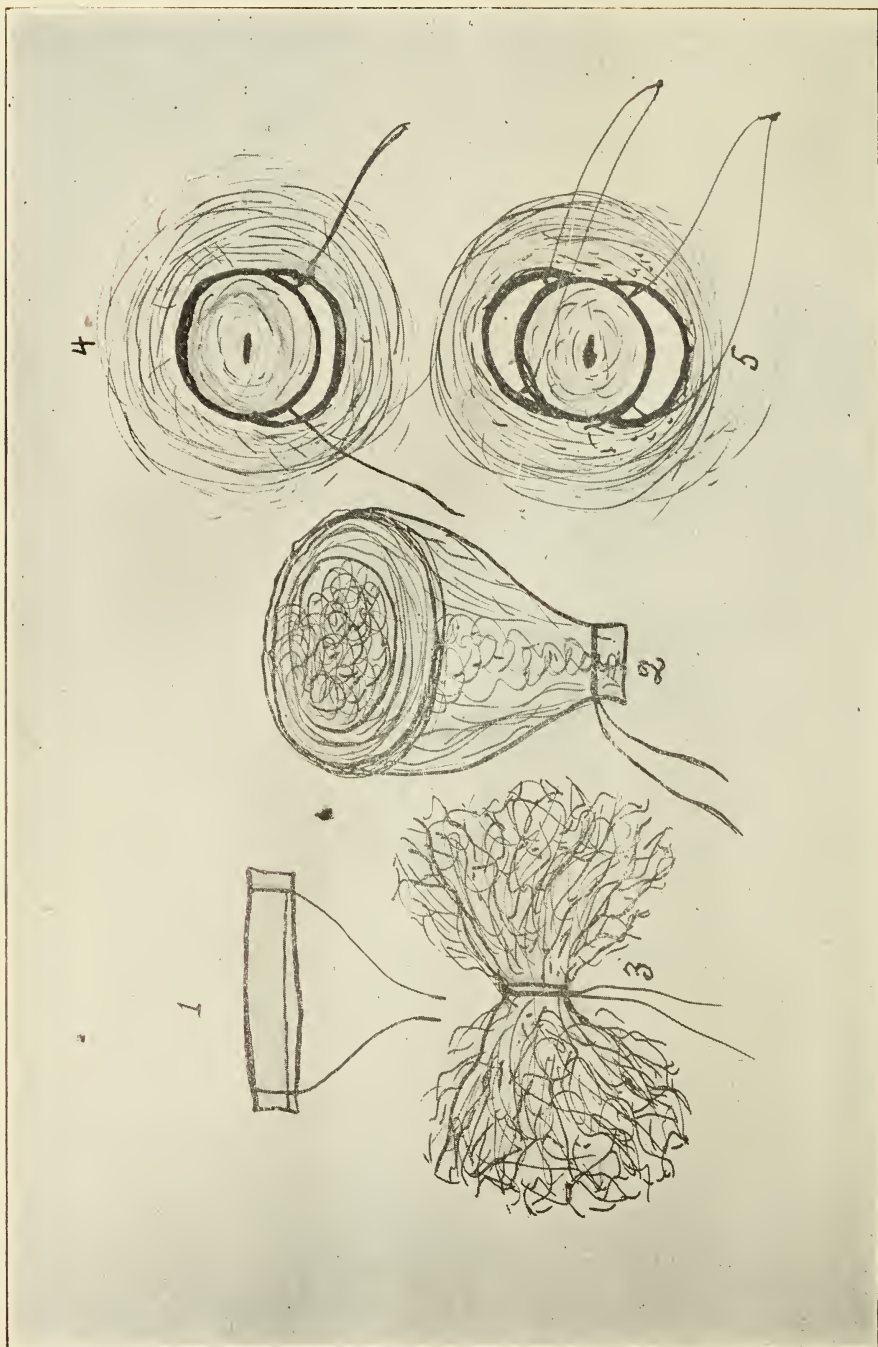


PLATE III.—DR. HARPER.

tient before we admitted our defeat and recognized the fact that "an operation would be necessary to clear up the condition?" Or did we treat the case lightly, diagnosing it as "**female trouble**," and considering it of no special consequence,—making an occasional superficial examination, and giving an occasional "treatment,"—dosing for various symptoms, and masking the real condition of things by an occasional dose of codeine or other opiate,—tiding her over her many paroxysms and soothing her into the belief that she was improving,—but never really finding out her real trouble, nor being able to intelligently cope with the situation,—till finally we awoke to the fact that our "treatments" had been in vain. and were glad to share our responsibility with the surgeon. After such results, is it any wonder that people in general,—both profession and laity,—have about lost faith in "local treatment"? The probabilities are that the "treatments" were given at irregular intervals, with no definite idea as to the effect, other than to act as a sort of soothing "poultice" for the time. Perhaps they did the patient no special harm,—if treatments were not too often repeated. Possibly they did some good if case was not of too long standing; but the probabilities are that we had all the time been exaggerating the condition or increasing the deformity which we vaguely hoped might be overcome,—and the organ finally becomes so firmly fixed in its malposition that there is little hope of relief, excepting from the knife. (See plate IV). We have been treating a deformity without first reducing it, putting a soothing application on a dislocated or broken limb, in the vain hope that nature will do the rest. Nature will almost work miracles, but she cannot overcome impossibilities. There are certain well established rules to be followed out in the treatment of deformities,—and our rules of surgery are applicable here,—that first we must reduce the deformity, and next, fix the organ or part in correct position, that nature may do her work unhampered. This leads up to a consideration of methods of reposition **and packing** in the treatment of retroflexions.

In order to avoid needless and exhaustive detail and explanation I shall confine myself to a consideration of retroflexions only as that is the deformity in which I first used the method, and for which the proposed instrument was devised. By varying or reversing the method, the instrument, as well as the principle of reposition and packing, may be applied to the various other malpositions with equally good effect.

Reposition is the returning of an organ to its normal position. This is a comparatively simple process with acute or recent cases, but in those long-standing ones of subinvolution with retroflexion and adhesions, it must necessarily be a slow and gradual one. Our ability to replace the organ depends largely upon the character of the adhesions,

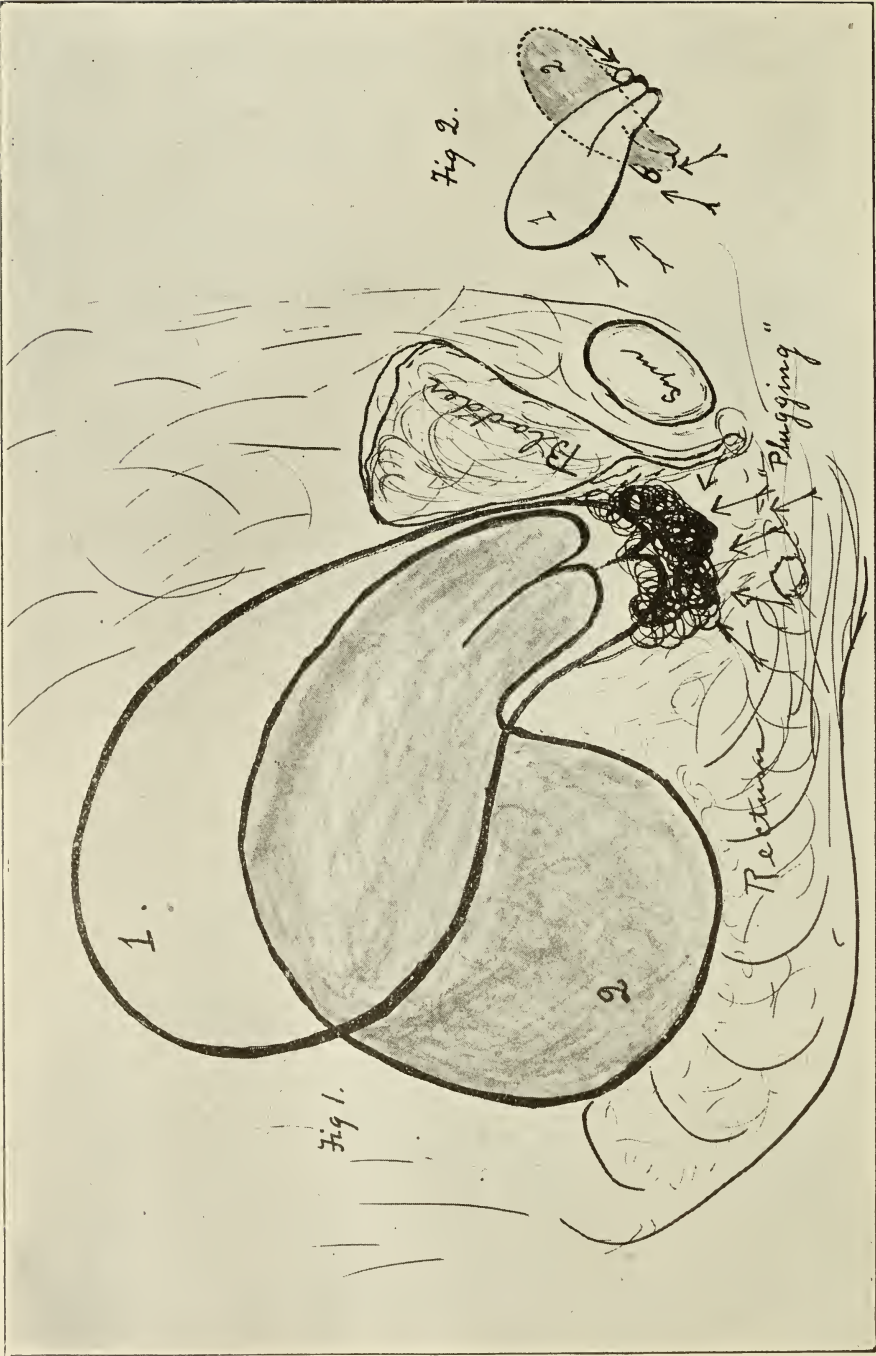


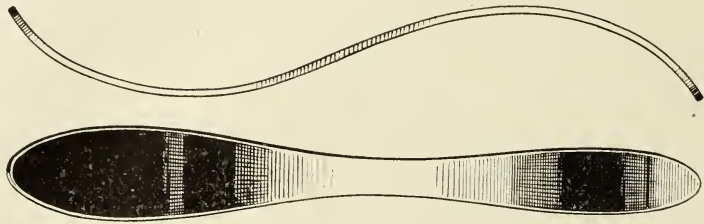
PLATE IV.—DR. HARPER.

the etiology and chronicity of the case, and co-operation on the part of the patient,—but it is simply wonderful how an apparently immovable organ can be softened and loosened up by proper manipulation, immediately followed by packing, for support and local medication. Many times an apparently firmly bound-down uterus will respond readily to this treatment, but probably the actual adhesions were not as massive as they first appeared, the organ having been held down by being caught under the uterine ligaments. This is probably a somewhat common occurrence in subinvolution with elongated and subinvolted ligaments. The cuts shown will indicate and explain the principles involved in this method of reposition and packing for support better than any verbal description could do.

The mechanism of this method is the adaption and application of truly scientific principles to practical purposes. The principle of the lever is a scientific fact. A lever of the first class class is a simple contrivance, and easily understood, with fulcrum between power and resistance. This is the foundation principle of our treatments.

Given a case of retroflexion; patient in dorsal position; a firm cotton roll, saturated with hamamelis and boroglycerid is introduced through the speculum and placed at right angles to body in posterior fornix, and pressed firmly into place. The roll is our fulcrum. Now, to lift the load (body of uterus) force is directed downward upon **anterior** aspect of cervix, and to straighten out flexion and assist in the lifting of the load, we also apply a lifting force, upward and against posterior aspect of body of uterus; this latter force being best applied through rectum, from which vantage ground the entire organ and appendages may be easily palpated and definitely located. However, in the dorsal position we are working at a disadvantage,—**working against gravity**, which tends to hold the fundus downward and backward in the pelvic basin. Now change roll to **anterior** fornix. **After the roll is properly adjusted in the anterior fornix**, speculum may be removed, and patient changed to the knee chest position. We have now reversed the order of things,—air rushes in and distends the vagina, greatly aiding us in reposition, and instead of working **against**, we **assist gravity** in carrying fundus forward. With one hand operating through rectum, and the other over abdomen or within vagina, the position is easily controlled and manipulation made easy; and this roll, which acts as our fulcrum, will later on serve as our “rest” or support in holding position gained. However, as the uterus is carried forward it soon gets beyond the palpating finger in the rectum, and we are hampered in our efforts at reducing flexion and effectually massaging and reducing irregularities in posterior aspect of fundus. This is the rock against

which I struck. The finger is a most sensitive, effective and intelligent instrument in such cases, as far as it goes, but an instrument which would give a firmer, broader and more even pressure, and farther reach in all directions, was certainly something to be desired. After many ineffectual attempts to procure something which might answer the purpose, and using various makeshifts, the plan of the new instrument was worked out, and my only apology for it is that "**Necessity is the mother of invention.**"



Uterine Repositor, (Harper) $\frac{1}{2}$ size.

Reposition for a retroversion would be a more simple application of the lever principle. (See Plate II.) Just imagine the organ in retroversion, **moving as a whole**, and poised in such manner as to move upon a central pivot, and describing a circle. Slight force applied downward to an anterior aspect of cervix would send it spinning over to anterior position. In a case of retroflexion the mechanism is necessarily more complicated, as we are rotating the organ on a central axis, and at the same time overcoming flexion, thus making the process a slower and more tedious one.

Well, thus far the plan seems all right, and simple, and easy to follow, but, "**but,**" the next thing is to hold organ in place after such reposition. To go back to our surgical principles,—a deformity must first be overcome or reduced; and next, held in position until repair is complete. The uterus is a very mobile organ, having no really fixed position, consequently it is very difficult to "splint" or "fix" satisfactorily. Those to whom I have broached this subject, have, with one accord, expressed themselves as being very sceptical as to our ability to hold the correct position, even after replacement. Did you ever see a man driving up a long, steep hill with a heavily loaded wagon? He stops a number of times to rest his team. What does he do each time he stops? He **blocks the wheels!** That is just exactly the principle upon which we must work; at each treatment **we must block the wheels** if we expect ever to get to the top of the hill with our load. To carry this further,—when the man gets to the top of the hill and starts down the other side **he applies the brakes! So must we!** After the uterus has been carried

forward past the mid-point, or "**danger point**" as Ashton calls it, our packing must be so modified as to serve as a sort of "brake," rather than a "rest" on an up-hill grade. It will be seen from the above homely application of the principle of reposition and packing for support, that it is not simply a theory, but is eminently practical and easy of application.

The following will illustrate plan of treatment:

1. To reduce a **posterior displacement**, use knee-chest position, packing for support(or manipulation) in **anterior** fornix.
2. To reduce an **anterior** displacement, use dorsal position, packing for support (or manipulation) in **posterior fornix**.

If we definitely diagnose the malposition, and correctly make application of the principles above outlined, **we are bound to get results**, in spite of ourselves.

In packing for support, I use what I call my "cotton pessary," a tightly rolled piece of absorbent cotton, of such size as suits the case, and tied at each end with a cord, leaving the two ends of cord separate to aid in adjustment of roll, after which they may be tied together to form a loop. (See Plate III.) The single roll may be used for definite action and support, or double roll if slight but firm opposing action is desired,—one giving **active**, the other **passive** support, depending upon position of fundus. Now, for special medication and gentle counter-support, a cotton wool, or pure lambs wool tampon is introduced through speculum, saturated with whatever medicine may be required for the case, which serves as a soft bed upon which cervix rests. Always bearing in mind our fundamental principles underlying **reposition** and **packing for support**, we may reverse and modify method to suit any malposition which might arise.

Another thing worthy of mention here: In nearly all pelvic displacements there is also a general relaxation of the abdominal walls, which calls for effective support, if best results are to be expected. The ordinary corset is a discomfort, a detriment, and worse than useless. I have had the best results by having the patient wear a "hygienic" straight-front, **front-laced** corset, thus relieving the viscera of the uncomfortable and injurious pressure from the ordinary stiff front steels, and holding the body easily in correct anatomical position, giving firm pressure and easy support just where needed.

I have purposely avoided the topic of general medication and treatment, as well as special medication for local application, as this article was originally intended to deal only with the mechanical principles involved in treating retroflexions by reposition and packing. Nevertheless I feel that to dismiss the subject thus would be irrational and perhaps somewhat misleading, and as incomplete as would be an article

which treated of general systemic medication alone for these conditions. Someone remarked to me not long ago,—“I think we are apt to promise our patients too much from **local treatment alone.**” Yes, and another man actually promises to **cure with systemic remedies alone!** One is just about as rational as the other,—as reasonable as the Christian Scientist who gives the “absent treatment” for everything from a burn up to diphtheria! They may all get results,—**but what results!**

The rational treatment in retroflexions, and diseases of women in general, **is to treat the woman in general**, as well as **specially**. Every organ or system of organs should be systematically interrogated, and so tone up and build up the **woman as a whole**, by every means within our power. Nature is our sheet anchor and our aim should be to so conserve her forces and treat as to her aid in carrying out her reparative work without undue loss of energy.

With definite aim in view, and intelligently applied, electricity, vibratory massage, baths, douches, etc., etc., work much good, while general and special treatment systemic medication, and local applications and treatments are necessary. A regular routine course of treatment should be instituted if we expect to secure good results, and the co-operation of the patient must be secured in regard to the care of herself in the interval between treatments. This latter is a matter not always easy of control, for after suffering for months, perhaps, almost as soon as the load is lifted, pain and pressure symptoms subside, and the woman feels so much better that she thinks she is about well, and the first thing you know she is “**taking in washing**” or doing her own house-cleaning,—with a “backset” to overcome as a consequence.

We need to broaden out in our methods of treatment in these diseases,—both medicinally and surgically. The intelligent, thoughtful and unprejudiced medical practitioner or surgeon will bring to his aid and the relief of his patient, every rational means within his power, irrespective of “**cult,**” or “**path.**” A happy combination of such general and local measures is bound to bring us to and our patients the happiest results, while the use of half measures will as surely bring disappointment.

In conclusion the subject of medical gynecology is one which should merit our earnest and thoughtful consideration. The indifferent results generally obtained from “treatment” (?) utterly discouraged me at one time, as it has many others, and I decided either to give up such efforts entirely, or to find some rational method whereby some definite results might be secured. Now, comparing results of this method herein outlined with previous indifferent and unsatisfactory ones, I am so convinced of its value, that were I obliged to resume the old way again, I would feel like making no attempt whatever in this line of work.

CASE REPORTS.

CASE I,—2—para; menstrual trouble and indefinite symptoms date back to a month or two after marriage; became pregnant about a year and a half later. Recovered somewhat slowly after first labor; after getting up suffered from prolapse and almost constant "bearing down" feeling. However became pregnant again within a year, and was delivered at term of a fine big healthy boy, who is now four years old. Again a tardy recovery,—if "recovery" it could be called; being on feet brought uterus down even worse than at previous confinement, until life became a burden. Her physician instructed her to "go to bed and stay there," and he could cure her, although he had never once made an examination to determine her real condition, but told her if she would stay in bed long enough the parts would go back. Well, gradually the prolapsed organ did go back and stayed back, and she thought of course, she must be better—or ought to be—as it did not come down any more, but she really felt worse, why, she could not tell, a great weight seemed to pull at her down at her back, which was never free from pain, and there seemed a great mass of something in the rectum, which urged the bowels to move, but really obstructed them, causing great pain at each action, until finally they moved only when urged by an enema or some purgative. For over three years she was "treated" at long range, taking medicine almost continually, to no effect, symptoms all the time growing in intensity; menstrual periods recurred every three weeks, scantily, often accompanied by convulsions, dysmenorrhea being so intense as to confine her in bed for several days at each recurrence. Having grown so progressively worse, in desperation she came to see me, not with any definite idea of getting relief by any treatment, but that she must talk freely to someone, and "tell her troubles." She had not had a good night's rest for months—she could not tell when—and for a week had hardly slept at all, as she could lie in no position to be comfortable. She breathed in short gasping breaths, and every breath she drew was a pain; was very nervous and weak, and had to be brought to the office; countenance anxious and drawn with pain.

Examination was specially difficult, the abdomen being very much bloated and exceedingly sensitive to the touch. Uterus and adnexa a great, hard, corrugated, pulsating mass, lying flexed upon rectum, and excruciatingly painful. The flexure between cervix and fundus was most marked, the latter being firmly bound by adhesions, and immovable; cervix much elongated, and of a dead white, or greyish hue, looking and feeling like cartilage or tendon; os and cervix patulous up to flexure, admitting little finger as far as internal os, probe passing easily on to bend, to which point it measured two and one half inches. Parts were entirely without tone and relaxed.

Frankly, I felt that I was up against a hard proposition and had very little hope of doing anything more than to perhaps make her somewhat more comfortable and get her into a more favorable condition for operative measures when they should be decided upon; an operation for relief at this time could have been nothing short of a most radical one. Treatment was commenced, every other day at first, the first manipulation being directed toward straightening the canal, with the result that in about two weeks the menstrual flow came on more profusely and with less pain than she had experienced for years. However, very little impression seemed to have been made upon adhesions, as uterus remained firm in its malposition, until the end of the first month of persistent manipulation and treatment—when, lo, adhesion seemed to "let go" and the organ went forward with a perceptible "flop!" I need not go into details in regard to encouraging and discouraging features of this case, but at least it grew no worse. Gradually various improvements were noted, as general systemic conditions were improved: the uterus

decreased in size and settled down into a definite position instead of persisting in "flopping about" with every step or movement of the body, and patient gradually became unconscious of the existence of such an organ. Two months and a half of treatment got patient into somewhat more comfortable condition. At the end of this time I went east for six weeks, during which time she continued her home treatments of baths, douches, etc. Upon my return I was much gratified to find conditions no worse. One feature, however, I still observed, which did not encourage me, and that was the relaxed, elongated, patulous cervix, of that dead white hue and cartilaginous feel and look. The organ was freely moveable and packed well, but it still lacked tone. Treatment was resumed, packing being removed only a few hours before next treatment to allow for cleansing douche. Slowly and gradually the pink began to come to cervix—it began to look alive—and that cartilaginous feel began to soften down, and os became less patulous. I felt that we were gaining ground. And we have gained ground ever since steadily. During all these months of treatment uterus has been markedly displaced backwards but once, and that was due to over-exertion. One day, feeling unusually well, patient decided to do her own sweeping, instead of waiting for some one to do it for her. She swept several thick carpets, dusted, and the various et caeteras of a general house-cleaning, with a return of her old pain and pressure symptoms, which she was unable to relieve by douching or any position which she might assume. After a sleepless night she came in for treatment. Uterus was found much swollen and tender, and lying flexed upon rectum. Slight manipulation in knee-chest position replaced the organ, bringing immediate relief, since which time there has been no recurrence of the displacement. Today this patient is rosy, plump and fresh looking—talks with a ring to her voice, walks with a spring to her tread, and the outlook for giving the surgeon a job—is bad for the surgeon! She says she is willing to take treatments five years longer—and keep her anatomy all together, if it be necessary.

This case has been an especially interesting—a most vitally interesting one to me, as demonstrating the method of treatment which I have outlined and used. If this method of treatment has done so much for a case of such gravity and chronicity, what are the possibilities of such treatment in cases of less chronic nature—those cases which visit the average doctor's office month after month and year after year, vainly seeking for aid, and later on turning to the surgeon for the hoped-for relief?

CASE II will illustrate the opposite extreme. Case of subinvolution with marked retroflexion following abortion; four months standing. Symptoms were acute, constant pain and pressure symptoms, growing progressively worse; pulse 120; temperature 101.6, abdominal tenderness and swelling. My better judgment suggested a curetment as a preliminary, but this sounded too much like "operation" and patient would not hear to it. The first great relief, which was remarked after first treatment, was the lifting of the weight and aching from back by raising fundus from rectum and relieving stretch on ligaments; the next was relief from the dysmenorrhoea from straightening the canal. Aseptic and antiseptic treatment, both local and systemic, cleared up her trouble like magic, pressure symptoms and pain not returning after second or third treatment. Menstrual period recurred, free and somewhat prolonged, and absolutely painless, producing sensation of relief and well being, instead of former "dragged out" feeling, a regular nature's curettement. This case was treated one month.

CASE III.—Young woman of 20. One baby 18 months old. Had always the best of health up to four months ago, when she aborted at 2½ months. Did not go to bed, but remained up and about the house. Had flowed almost continually all this time—at times amounting to a flooding, when discharge would be a bright red; at other times black looking and very offensive, coming in shreds and clots. Had done nothing in par-

ticular, but taken the varied advice of friends, until finally uterus dropped down and she suffered constant bearing-down feeling and pain in back. She came in for treatment. Uterus prolapsed, cervix being almost on a level with vaginal opening; fundus enlarged and nodular; right ovary and tube enlarged, hardened and adherent, and exceedingly sensitive to the touch, fundus being considerably drawn to right side; offensive, purulent discharge, streaked with blood. Almost constant headache, slight temperature, sallow skin, coated tongue—everything pointed to septic trouble. Another case in which curetment seemed first indication, to which she strongly objected. (I am learning that in many of these cases nature attains this end more easily and safely than we can, if we but produce favorable conditions for free drainage by proper manipulations in the right direction, dilating and straightening canal, and packing and holding organ in correct position). At the end of a week the offensive discharge had ceased. In about two weeks free, natural menstrual flow came on, bringing away considerable debris, but without offensive odor, and lasting about four days. After this canal was kept well dilated and free to drain for a time, with a rapid shrinking and softening of fundus. Now at the end of five weeks' treatment, uterus is in good position and condition, and right ovary and tube rapidly assuming a normal feel—soreness almost entirely gone. A very few more weeks of this improvement will take her out of my hands.

CASE IV. Young primipara, 20 years, baby four months old, fat, good natured and healthy. Somewhat difficult labor with slow recovery, accompanied by hysteria, convulsions, and various nervous manifestations—merging into mania. At times was unsafe to leave alone with her baby, as she felt uncontrollable desire to crush it or do it bodily harm. Was treated locally for about six weeks after birth of her child, and discharged as well, but various nervous symptoms persisted. They moved to Pittsburg, and husband brought her in to me for advice and medicine. She presented the appearance of one mentally unbalanced—wild-eyed, nervous, and started at every sound; hands, feet and head constantly moving and twitching. She had suffered from constant pain and pressure in top and back of head ever since confinement. She insisted that she had no uterine trouble, whatever, that the doctor who had treated her told her that she was all right there, and only needed to go to work to throw off her nervousness. She refused to be examined, and only wanted some medicine "to cure her nervousness." Advised her that a thorough examination would be necessary to definitely locate her trouble, and probably would require a regular course of persistent treatment to remove it. She would not decide about it until later, so medicine was prescribed to perhaps relieve her for a time—which it did. She came in three or four weeks later for examination and treatment. External and internal genital organs in a hyper-sensitive condition; enlarged and hardened uterus lying flexed upon rectum; sensitive areas along spine—particularly at base of brain, between shoulders, and in sacral region; two very sensitive spots immediately above waist line on either side, just at exit of nerves. Treatment was commenced, the first move being the lifting of the uterus and packing it in correct position, relief being experienced from first treatment and she remarked the pressure lessened. The fourth time she came in for treatment she remarked, "I don't have headaches any more." She has now been under treatment a little over two weeks and she really sees and feels that she is getting better every day. She can sit quietly and says she feels "let-down" instead of "keyed up to a high tension" as she had felt so long, and has entirely lost the feeling that she must crush her baby when caring for it. Local treatment for the uterine condition and electrical and vibratory massage and heat, tonics, nervines, etc., and her home treatment of bathing and douching, with her walk of a mile every other day to take her treatment are working wonders for her—are keeping her mind occupied and busy.

CASE V. Married woman of 32; 2-para,—oldest child 12, youngest, 8 years old; trouble dates back to birth of first. Has taken local treatments—months at a time—for years, from various physicians. Eight years ago was advised that the only way to cure her was to have ovaries removed; however refused operation. After having been treated intermittently all these years, and being given up as an operative case, she visited a surgeon who advised an immediate operation; he really could not tell just how bad the condition was, but desired “the option of removing whatever organs or parts” he should deem necessary at the time of the operation. However, her husband absolutely refused to have her “cut up,” as he expressed it. She presented herself for examination and treatment. Considerable gastro-intestinal distension, with eructations; abdominal tenderness. Region of umbilicus sensitive and depressed, and feeling as if firmly adherent to internal parts; she complained of its feeling as if some weight pulled it down and back, which described direction of pain and aching in back and sacral region. Large and nodular varicosities in right limb, extending from ankle to about six inches above the knee, which stood out in great knotted cords when standing. Bowels particularly sluggish, and difficult to move. Uterus enlarged, hardened and sensitive to the touch, and lying flexed on rectum. Manipulation in knee chest position carried uterus well forward, demonstrating that adhesions were light or absent. This case has not been under treatment long enough to demonstrate what may be done for it, but it has responded well to treatment thus far, and with the full cooperation of the patient I do not feel at all dubious over prospective results—especially after obtaining such results from treatment in Case I.

I might merely mention five other cases taken at random from record book which were under treatment all the way from three weeks to four months; two resulting from abortions, and three from labor at term. In only one case did I find it necessary to curet to get rid of adherent secundines. All have made uneventful recovery. The causes, conditions and general symptoms in these cases were practically the same—resulting in subinvolution with retrodisplacement, a most prolific cause (I might say the most prolific) of surgical interference in diseases of women—a condition apparently little understood and unintelligently handled by the general practitioner, and which, from sheer force of habit is delegated to the surgeon.

The Third Congress of Climatotherapy and Urban Hygiene will hold its meeting, during the Easter vacation, 1907, on the French Riviera (that part between Hyeres and the Italian frontier) and in Corsica.

The sessions will be held at Cannes, Monaco, Mentone, and Ajaccio; but all the towns and stations on the Mediterranean Littoral are included in the program:—Cannes, Nice, Monte-Carlo, Mentone, Hyeres, Antibes, Grasse, St. Raphael, Juan-les-Pins, Beaulieu, Cap Martin Thorence, etc.

The congress will last about one week on the French coast and will finish in Corsica.

The Military Surgeon is the new name for the Journal of the Association of Military Surgeons. Major James Evelyn Pilcher is the editor and has shown great energy in building up and modernizing the journal. It is published at Carlisle, Penn.

Correspondence.

Newspaper Advertising.

To the Editor:

It is evident that the advertisement question is being generally considered by the profession. Lately the JOURNAL has given us samples that are not altogether creditable to the profession. Physicians are actuated by the same impulses that business men are and are seeking to extend their patronage. In the November JOURNAL on page 500 you intimate that the code is too strict. You state a space you believe a physician might be allowed to occupy in a newspaper and suggest a form he might use and keep within the requirements of the code. If the form suggested would tell the truth about the man who used it, no one ought to object. Neither ought one to object if one used an entire page to inform the public of his location, etc., always providing he conformed to the truth and paid the printer. Why should one inch in a paper be ethical? Why should a column make the man a quack who used it, if the same words occurred in each? The simple legend, Dr. John Smith, Physician and Surgeon, which appears in nearly every paper in Kansas, is often half untrue, and occasionally wholly so. The legend should read "Dr. John Smith, pill peddler," to be true. But Dr. John Smith observes the traditional form, and is therefore ethical. If he were bright, an intelligent prescriber, and a competent surgeon, and said so, in a double column next to reading matter, he would be a quack. That is about the attitude of the devotees of the code.

Many of our brightest men were advertisers in their early career. I could name a score. So can you. It is strange, but a physician may own a drug store, and send out his name over advertisements for Doane's Kidney Pills, Lydia Pinkham's Remedies, and Peruna, and be ethical. He can even own and advertise a cafe, a livery stable or a dairy and remain in good standing. But if he invests in a good office equipment and puts a clean stock of drugs in his office, and then advertises these facts to the people of his community, he becomes a quack. Strange, is it not, that it is quackery to advertise the fact that one has taken a post graduate course, or has equipped his office and is able to treat diseases well, but that it is ethical to advertise Doane's pills from the ground floor room below the office. In the sense of earning a livelihood practicing medicine is a business. It ought to be a business where one engaged

in it would seek to invest at least a part of his surplus. Physicians seek outside investments because the code forbids them to give the publicity to the medical investments, which would make them pay. Advertising is not a crime. Deception, misrepresentation and back-biting are, or ought to be. You tell how the Iowa physicians were forced to use the papers to inform the public about the hospital matter. Dr. Sutcliffe is not the only sham that needs the sunlight of publicity. There are a few others in the regular profession that might require the purge of printers ink to make and keep them clean. The profession ought to awake to the value of printers ink. The Christian Scientist understands its value. Every county society should buy newspaper space and expose the shams in and out of the profession fearlessly and truthfully. We need the press on our side. The editors want to be with us but the quack and patent medicine men are the ones that spend the money in advertising. How can an editor go back on the man that pays the rent, and spend time and space in the interests of the men who are resolving that he shall not even mention their names in his paper?

If one half the money spent by such people as Peruna, Dr. Bye, etc., was spent by the profession, to impart needed knowledge to the people and correct the wrong impressions that gain currency, the press, or the decent part of it, and that is at least nine tenths, would be only too glad to drop the patent medicine advertisements.

If osteopathy had been investigated thoroughly ten or twelve years ago, its cures and failures published side by side its good points and pretensions stated fairly and fully we would have little trouble with its votaries now. If a quack doctor were done thoroughly in every paper in Kansas, and testimonials from his dissatisfied dupes published, he would soon find his victims few. If the analysis of Peruna and Hostetter's Bitters had been common property of the papers and the people years ago, Colliers Weekly would not have found it necessary to publish the Great America Fraud Series. The people don't half appreciate the value of physicians. They ought to be told. If we are not appreciated it is our own fault. Irregulars and pretenders have discredited us and we have held our peace. Quacks and charlatans have called themselves by our names and we have been dumb. Patent medicines have claimed cures where we have failed, and we have remained silent. How are the people to know that we are not of the same stripe as the quack? How can they know that the patent medicine claims are false?

Let us start on a campaign of publicity and let it be without malice but thorough. Let fraud be exposed even if some of our pillars of strength are destroyed. Let us purge our ranks and deserve the confidence of our patients and we will have it. A campaign of education

would direct hundreds of thousands of dollars from the coffers of medicine companies and quacks into the pockets of the physicians and the people be the better for the diversion. Publicity would make the advertiser careful of what he said to the people, and as exposure of the false claims would follow speedily, he would find any but truthful statements unprofitable. Then the spirit of the code would be observed as violation would not be wise or profitable.

A FOLLOWER OF CARLYLE.

[Editor's note: We would reiterate that the medical profession must be guided by the dictates of dignity and taste in all its dealings. A full page advertisement would violate both taste and dignity. If an announcement of the location of a newcomer be needful, then it should be as quiet and dignified as possible. Each county and locality must decide what its own conditions make necessary, and should not hesitate to use the newspapers if the occasion demands it; but such use should be restricted to that absolutely necessary. For it is a fact that the solid men, the men that amount to something in the long run, are the ones who are least heard of in an advertising campaign.]

Albuminuria:

To the Editor:

Twenty-five years ago I was a resident of Kansas and for many years past I have watched with interest the rapid development of the state.

The progress in medicine in Kansas has been phenomenal. No journal of any State Medical Society is more up to date than the Journal of the Kansas Medical Society. I was especially interested in the last (December) number.

Dr. John G. Sheldon's article on "The Significance of Sugar in the Urine in Surgical Patients," is timely and of great value. I wish, however, he had dwelt more upon the glycosuria and acidotic conditions resulting from traumatism.

It was very early recognized that traumatism produced profound metabolic changes, even when applied surgically. To one of the surgical consequences Dupuytren applied sixty years ago the term *delirium traumaticum nervosum*.

The relationship shown in the alternation of diabetes with the psychosis threw some light on the underlying element of this *delirium traumaticum nervosum*, as also did the relation of gout and rheumatism similarly with like nervous and psychic states.

It is known that even the slightest traumatism, surgical or otherwise, may be accompanied with glycosuria and acidosis. Coriat has shown that all the depressed states are accompanied with acidotic conditions, which are the product of suboxidation that follows depression and continues it. The same factors following surgical operations have been recently observed by J. A. Kelly.

That traumatism arising from accidents may produce glycosuria and allied states has recently been legally decided in London.

Previous to and after every surgical operation careful uranalyses should be made. Uranalysis in surgical cases tends to indicate that the constitutional effect of operations is along the line of interference with oxidation, and that many of the cardiac strains are really due to increased arterial tension, arising from maloxidation.

If the urinary degree of acidity be less than 30, the acids formed are not being excreted, and are tending to accumulate in the system. If the urine contains acetone, acid formation is proceeding at an intense rate, and this is still more the case if diacetic acid be present; while the presence of B-oxybutyric acid indicates deep-seated, intensely poisonous metabolic changes. A decrease in the acidity of urine in a traumatic (whether surgical or not) indicates the imminent possibility of some nervous explosion, which may vary from an intense neuralgia to coma, and to an agitated confusional insanity.

The therapeutic indications are to decrease acidosis by the use of alkalies, pre-eminent among which is sodium bicarbonate, and to increase elimination. As the strain is chiefly on the kidneys, elimination should be diverted from these organs to the intestinal canal by the use of hydragogues, such as elaterium, chionanthin, etc., followed in a day or two with a saline laxative which should be continued for some time.

The cardiac strain, resulting from exaggerated arterial tension due to the acid states, should be guarded against by the use of respiratory stimulants like strychnine and aspidospermine, since these drugs better than any others will give tone to the heart and increase oxidation, the diminution in which is one great factor in the acid conditions, whether resultant on traumatism, or in other causes.

The question of sleep, or rather, of rest, will require attention. Were it not for their effect on the intestinal secretions, opium and its alkaloids would be ideally indicated, since they are good cardiac tonics as well as narcotics. The influence which opium and its alkaloids have on the secretions, however, contra-indicates their use (with the exception of apocodeine muriate, which alone has a laxative action). Heroin has less inhibitory influence than morphine, but its exhibition hypodermically is apt to be attended by nausea.

Dr. Seabrook's paper, "Diabetes Mellitus and its Curability" interested me as does nearly every contribution on this subject.

When reading Dr. Seabrook's article, I was reminded of the interrelation of diabetes and other constitutional states.

Conditions such as express themselves in glycosuria and allied suboxidations readily occur in the neuroses. Hysteria may be compli-

cated for instance with glycosuria of transitory or prolonged duration, which may eventuate in coma of an apparently diabetic type, but disappears with the disappearance of the most marked hysterical symptoms. The great neuroses, parietic dementia, locomotor ataxia and epilepsy, occasionally display temporary glycosuria. So do delirium tremens and the confusional insanities. Every one of the fibrile conditions may be glycosuric. Conditions in which respiration is involved are often accompanied by glycosuria. Pregnancy being a condition in which there is over-nutrition, faulty elimination, and resultant imperfect oxidation is often attended by glycosuria. Gout and insanity of the auto-toxic types frequently alternate with glycosuria.

Diabetic absorption of oxygen is much less than normal, and decreases till toward the end of the disease when it is hardly half the normal quantity. Carbon dioxide exhaled is proportionally reduced. The oxygen decrease, Sajous ascribes with much plausibility to suprarenal disorder. Increased suprarenal activity, as Croftan has shown, can so augment the ferment producing power of the pancreas as to greatly increase sugar elimination through the increase of the amylolytic ferment supplied by the pancreas which converts the liver glycogen into dextrose.

Herein lies the explanation of neuropathic glycosuria and of diabetic neuropathics. In the first, the cause is primarily in the cerebro spinal system. In the second, the system composed of the liver, pancreas, spleen and adrenals is first affected, and the resulting toxic products because of disordered oxidation, cause the nervous symptoms.

In treating diabetes and glycosuric and acidotic states we must remember that four things are necessary, no matter what other treatment is employed.

1. Increase oxidation. This can be done by the administration of strychnine and aspidospermine, and by hydrotherapy. Cold sponging down the spine and on the inner and outer aspects of the thighs is apt to be attended by a rapid tonic reaction, which increases the circulation from the interior to the exterior, thereby tending to increase oxidation.

2. Favor elimination by all channels. The kidneys may be in good condition themselves, yet because the intestines are acting imperfectly with fecal resorption, the kidneys are overworked, as is shown by the presence of indican and urea in the urine. Secondary to this occurs renal insufficiency with resultant acidosis from retention of imperfectly oxidized sugar products. Free purgation by means of hydragogues and hepatic stimulants, such as elaterium, chionanthin, baptisin, apocynin, leptandrin, podophyllin, etc., with a saline laxative is urgently indicated.

3. Overcome acidosis by the free administration of a saturated solution of sodium bicarbonate.

4. Counteract tendency to autointoxication, particularly intestinal toxemia. This can best be accomplished by diuretics, diaphoretics and especially by laxatives, such as I have already mentioned, together with intestinal antiseptics, the best of which are sulphocarbolates with bile salts.

The common erroneous assumption that morbid states occurring during a diathetic state are due to it, is peculiarly accepted as to diabetes. While there is more truth in the assumption as regards diabetes, still treatment of symptoms and local conditions will often do as much to relieve diabetes as treatment of diabetes does to relieve them.

GEORGE F. BUTLER.

103 State St., Chicago, Ill.

The Report of the Parsons Hospital for Epileptics for the biennium ending June 30, 1906, gives the reader considerable food for thought. Superintendent Perry gives thirteen pages of report, in which he tries to show the absolute necessity of greater appropriations and more business like methods. He says that the board of control system is an improvement over its predecessor but that there still remains much to be done before the institution will be as well managed as would a private business of equal magnitude. It strikes us as peculiar that an institution wherein the treatment is largely by the use of agriculture, should be located in a place where the soil is notably thin and the surface drainage poor. We have heard stories about the sum of money which Parsons sent to the legislature to secure the location of the institution there. The report of the superintendent about the soil, and about the step-mother-like treatment afforded the institution by the Parsons water department and the natural gas company, leads us to believe the story true. Dr. Perry is handicapped by a lack of buildings and equipment generally. Evidently appropriations and plans have been made with small consideration of professional needs and wishes. However, we hope that the new board of control will do better by the institution.

Location—I have a good location which I will give free to purchaser of my drug store. The stock will invoice about \$475. Ability to speak German will be of assistance. I want to leave by Feb. 1st, to take a post graduate course.

DR. JAMES WELCH, Tampa, Kansas.

Society News.

The Council meets February 5, at Dr. Munn's office in Topeka.

The Cherokee County Medical Society held one of the best meetings in its history in Galena on Tuesday 12-11-06. There was a large attendance from all over the county. Two applications for membership were favorably reported, which, if elected, will give us a total numbership of about 31 out of about 55 registered physicians in the county. A steady campaign is being conducted among the non-members and before the end of the year we expect to have all the eligibles enrolled. Two excellent papers were read and freely discussed by the society. Dr. Fred D. Northrup on Pneumonia and Dr. Chas. S. Huffman on Quarantine and Fumigation. The program committee reported a program for 1907 which was adopted by the society.

The officers for 1907 are: President, J. P. Scoles; Vice President, R. C. Wear; Secretary and Treasurer, R. C. Lowdermilk.

The question of fees for insurance examination was discussed at length, and resulted in the adoption of the following resolution offered by Dr. Chas. S. Huffman, Secretary of the State society.:

RESOLVED: That it is the sense of the Cherokee County Medical Society that five dollars is a fair minimum fee for life insurance examinations and we ask that this matter be taken up at the meeting of the state society in that they adopt a resolution pledging the members not to make examinations for the old line companies for less than five dollars.

The next meeting will be held in Baxter Springs, Jan. 8, 1907.

R. C. LOWDERMILK, .

Secretary

Clay County—Program for January 8, 1907:

"Tonsillitis" Dr. R. C. Harner, Green
 "Fractures and Their Management," Dr. J. P. Kaster, Topeka
 "Nervous Diseases," Dr. Lyman L. Uhls, Osawatomie
 Dr. Porter is the new president; Dr. Olsen the new secretary.

Dickinson County—We had a representative crowd at our annual meeting, and the same was an enjoyable affair. The following officers were elected for the year:

President, Royal McShea, Chapman.

Vice President, E. E. Hazlett, Abilene.

Treasurer, J. D. Riddell, Enterprise.

Secretary, Chas. B. Buck, Abilene.

Censor, three years, Geo. E. White, Solomon.

Delegate to state society, J. D. Riddell.

Alternate to state society, P. B. Witmer.

Our society has twenty-two members; we lost two by transfer and gained others in their places. While our work has brought the profession into a more friendly relationship, much more along that line could be done. In the main our men are working along ethical lines. Only one man in the county is doing "contract lodge" practice. The question of a local hospital is under serious consideration and will be probably financed soon. Steps will be taken to call the attention of our druggists to their ethical relations, and especially to quack nostrums so publicly advertised.

CHAS. B. BUCK,

Secretary.

The Elk County Medical society met at Howard, Dec. 18, 1906. On account of a great deal of sickness and a cold day, there were very few members present. The meeting was called to order by the president, Dr. W. H. Smithers, in the chair. Minutes of the last meeting read and approved. The papers which had been promised for the meeting were not produced. The secretary read a paper on the registration law, which was well received. Dr. C. A. Trowbridge of Howard, made some felicitous remarks on his observations while in Europe attending the hospitals. The officers of the society were re-elected to serve another year. Our next meeting will be in January.

Jefferson County Medical society held its annual meeting in the office of Dr. G. W. England, Valley Falls, Dec. 27, 1906. The meeting was called to order by President Dr. E. C. Rankin, McLouth. An interesting program was given, consisting of talks on the following subjects:

"The Treatment of Gonorrhoea,"

"The Old vs. The Young Physician."

"Specific Medication."

"Consultation."

"Value of Hospital Facilities in Country Practice."

Annual election of officers resulted as follows:

President, Dr. Stephen E. Smith, Grantville.

Vice President, Dr. G. W. England, Valley Falls.

Secretary, Dr. L. V. Sams, Rock Creek.

Treasurer, Dr. W. L. Borst, McLouth.

Board of Censors, Dr. E. C. Rankin, McLouth; Dr. W. L. Borst, McLouth; Dr. Ira Puderbaugh, Ozawkie.

Delegate, Dr. S. E. Smith, Grantville.

The members were treated to a banquet and smoker, after which the meeting adjourned to meet in Oskaloosa about March 1. The new year bids fair to be one of the best for the interests of the Jefferson County Medical society. But three years old, it has enrolled among its members the full quota of eligible physicians in Jefferson county with the exception of three.

L. V. SAMS,
Secretary.

Leavenworth County—The annual meeting for election of officers was held Dec. 17, 1906. The result follows:

President, Stewart McKee.

Vice president, R. L. Boling.

Secretary, J. W. Risdon.

Treasurer, C. E. Brown.

Board of Censors, C. C. Goddard, A. J. Smith, P. W. Darrah.

J. W. RISDON,
Secretary

Montgomery County—We have added to our number Dr. E. W. Curd, Capon, Ind. Ter.; Dr. Milton T. Evans, Sedan, Kan.; Dr. G. W. Goss, Sedan, Kan.; Dr. W. T. Courtwright, Sedan, Kan. We have divided into four sections, to meet each at Cherryvale, Independence, Coffeyville, and Caney monthly. We will have four general meetings a year of the entire society. One at each town named. The 1907 officers are:

President, Dr. T. A. Stevens, Caney.

Vice President, Dr. H. M. Casebeer, Independence.

Secretary, Dr. J. R. Scott, Independence.

Treasurer, Dr. B. F. Fortner, Coffeyville.

Dr. W. H. Hall re-elected censor.

Delegate, Dr. I. B. Chadwick, Tyro.

The program of our last meeting follows:

Annual Address	Dr. T. A. Stevens
Report of a case	Dr. J. H. Dalby
A paper	Dr. I. B. Chadwick
Peritonitis	Dr. G. J. Bigelow
A paper	Dr. Mary J. Martin
	DR. J. R. SCOTT,
	<i>Secretary</i>

Shawnee County Medical society held its regular meeting January 7, 1907. The application of Dr. Kiene of Christ's Hospital was presented and referred to the censors to be reported upon at the February meeting. The censors reported favorably on the applications of Dr. R. A. Taylor

and Dr. A. B. Jeffrey, presented at the December meeting and both doctors were unanimously elected to membership.

The application of Dr. C. F. Menninger, which was presented at the December meeting was also favorably reported by the censors and the society elected him to membership on the condition that he resign from his homeopathic societies. Dr. W. E. McVey and Dr. O. P. Davis were appointed a committee to circulate a petition to congress against the osteopathic bill. The insurance resolutions recommended by the Kentucky State medical society were adopted.

CORBAN E. JUDD,
Secretary.

Washington County—The second annual meeting and banquet of the Washington County Medical society was held in this city Wednesday afternoon, and evening, December 19, 1906. The afternoon program consisted of a paper, "Some Thoughts Relative to Otitis Media" by Dr. H. L. Alkire, Topeka. The doctor presented his thoughts in a most skillful manner and the way he explained and demonstrated the anatomy of the middle ear, etc., by drawings (chalk) proved his ability as a teacher and was greatly appreciated by all present. The paper was discussed by Drs. Stewart, Algie, Rudolph, Schwartz, Gardner, Porter and Smith.

Dr. John Outland of Topeka presented his paper, "Diseases of the Cervix," in a very able way and it brought forth a general discussion by Drs. Porter, Stemen, Algie, Rudolph and Armstrong.

Dr. C. M. Stemen of Kansas City, Kansas, had a very interesting paper, "Extra Uterine Pregnancy" and reported four cases. The paper was enjoyed by all and discussed by Drs. Outland, Schwartz, Stewart, Porter.

Dr. John Punton, Kansas City, Mo., presented a very excellent paper "Nervousness, its Significance and Treatment," which was well received but owing to the lateness of the hour, the discussion was limited. The paper was certainly rich in thought and his advocacy of state aid and hospitals for the treatment of the curable cases of insanity should be taken up by the medical profession of the state. After the election of officers and the general routine of business, we adjourned until 8:30 o'clock for the banquet at which about twenty doctors and their wives were present. Dr. H. D. Smith performed the duties of toastmaster in a very pleasing manner.

Toast, "Our Profession," Dr. Robt. Algie.

Toast, "Medical Organization," Dr. H. L. Alkire.

Toast, "The Doctor," Sam'l Clarke, (Editor)

Toast, "Doctors' Dreams and Hopes," Dr. J. C. Rudolph.

Officers for 1907 are:

Pres., Dr. E. Armstrong, Greenleaf.

V. Pres., Dr. M. H. Horn, Morrowville.

Secy., Dr. H. D. Smith, Washington.

Treas., Dr. Wm. Jacobs, Washington.

Members present: Drs. Gardner, Armstrong, Horn, Runkle, Algie, Shearburn, Nelson, Rudolph, Tooley, Smith, Earnest, Jacobs, Maintz, and Snyder.

Visitors: Drs. Porter, Stewart and Schwartz of Clay Center, and Carter of Washington. Editors: Clarke and Ingalls.

Following is the corrected list of the members of the Washington County Medical society for 1906.

E. Armstrong, Greenleaf.

M. N. Gardner, Greenleaf.

Z. H. Snyder, Greenleaf.

Robt. Algie, Linn.

R. W. Maintz, Linn.

J. H. Hoover, Haddam.

E. W. Shearburn, Haddam.

J. C. Rudolph, Hanover.

J. O. Chambers, Hanover.

M. H. Horn, Morrowville.

H. D. Smith, Washington.

Wm. Jacobs, Washington.

W. M. Earnest, Washington.

R. A. Williams, has moved away, at present in Kansas City.

W. S. Runkle, Washington.

C. R. Nelson, Washington.

G. E. Tooley, Washington.

J. R. Mathews, Hollenberg, moved to Oneida and transferred to Nemaha county.

GEO. E. TOOLEY,
Secretary.

The Crawford County Medical Society met Monday evening, January 14, at the office of Drs. Bogle and Stelle, with the following members present: Drs. Graves, Bogle, Stelle, Wm. Williams, Sloan, Caffey, Cole, Harper. Following is the result of the election of officers for the ensuing year:

President, H. B. Caffey; vice president, Geo. E. Cole; secretary and treasurer, F. A. Harper.

Dr. J. J. Cavanaugh, of Walnut was elected to serve on the board of censors, succeeding Dr. H. H. Bogle, the retiring member. Board of

Censors: J. J. Cavanaugh, 3 years; E. O. Sloan, 2 years; Wm. Williams 1 year. Committee on public health and legislation, H. L. Stelle, F. L. Keeler and L. P. Adamson. Applications for membership received and acted upon favorably by the society: Dr. L. A. Newton, Chicopee, and Dr. Chas. Chapin, Frontenac.

Following is the report of committee appointed at a previous meeting to draft a set of resolutions condemning the unethical methods of advertising or reporting cases in the public press:

1. **RESOLVED:** That the publication in the lay press of the description of operations, attendance upon cases of sickness, and allied medical matters, in connection with the names of the members of this society be condemned.

2. **RESOLVED:** That the secretary be instructed to place in a scrap book, for inspection by the members all articles appearing in the press with the names of attending physician and that any member whose name appears have the privilege of attaching an explanation thereto.

3. **RESOLVED:** That a copy of these resolutions be published in the Kansas State Medical Journal.

(Signed)

E. O. SLOAN.

R. H. McDONNELL

H. H. BOGLE.

Dr. Geo. E. Cole brought to the attention of the society the importance of reporting all deaths and births to the county health officer; that many times questions of vital importance arose, which only the records of the county could clear up; such records can be correctly kept only as the individual physician sends in a report of his individual cases. The law provides that these reports be made or a penalty imposed. Proper blanks for this purpose are furnished by the county health officers. It is to be hoped that physicians will pay more attention to this matter this is the only way whereby the vital statistics of the country can be correctly obtained.

The use of the study of the Christian Church has been tendered the society as a permanent place of meeting; it is conveniently located, heated and lighted, and has telephone connection.

Adjourned to meet the first Monday in February.

FRANCES A. HARPER,

Secretary.

Western Kansas Medical Society convened at Colby, Kansas, January 9, 1907. Meeting was called to order by the president, V. C. Eddy, with the following members present: Drs. Eddy, Stoner, Blake, Marsh, Forbes, Carmichael, Beckner, Smith, Gulick, Lowis, Stroup, and Winslow. Visitors present: Dr. J. G. Sheldon, Kansas City; Dr. W. H. Schultz, Kansas City; and Dr. Townsend, Brewster. Usual routine of business was taken up and disposed of and the following officers for the ensuing year were elected by a unanimous ballot:

Dr. V. C. Eddy, Colby, president.

Dr. C. D. Blake, Ellis, vice president.

Dr. F. A. Carmichael, Goodland, secretary.

Dr. C. M. Miller, Oakley, treasurer.

The most important feature of the business section was its action in relation to the present existing fee schedule for old line life insurances, and it was unanimously voted that on and after February 15, 1907, no examinations would be made by members of this society for less than the minimum fee of \$5, and the following resolution adopted:

RESOLVED: That the resolutions adopted by the Kentucky State Medical society be and are herewith adopted by this society and that printed copies of the same with the names of all the members attached be furnished members that they may forward same to the several companies who are at present attempting to maintain the reduced fee schedule and that all physicians in the territory embraced in this society who are not at present affiliated therewith be furnished a copy of these resolutions and their cooperation in securing a just and equitable schedule solicited.

After the conclusion of the business meeting before adjournment an interesting program was rendered. Dr. Schutz of Kansas City presented a paper entitled "Some every day experiences in ophthalmology and otology," illustrated by superb drawings which was highly interesting and practical. Dr. J. G. Sheldon addressed the meeting on the subject of "Asepsis in emergency surgery," which was brief, but very forceful. Papers were presented by Drs. Stoner, Beckner and Stroup on the subject of Diphtheria and diseases of the tonsils, and the Asepsis in Obstetrics, which were carefully prepared and covered the ground fully. The next meeting of this society will be held at Oakley the second Wednesday in April.

Drs. Forbes and Beckner, Selden, presented a case of chronic appendicitis, one of cordiac spasm and one of complete procidentia uteri. Dr. Lowis of Colby, presented a case of hernia cerebri, which was a beautiful illustration of this rare condition. F. A. CARMICHAEL, *Secretary*.

The Annual Meeting of the Northeast Medical Society will be held in Holton, Thursday, February 14, 1907.

Program

The Interdependence of the general practitioner and the specialist	Dr. R. V. Adams, Holton
The county hospital	Dr. Benj. Skinner, Wetmore
Pure food	Prof. E. H. S. Bailey, Lawrence
Proposed state legislation in accordance with the pure food laws	Dr. G. E. Locke, Holton
Tonsillitis	Dr. R. C. Townsend, Centralia

Rheumatism.....	Dr. Noah Hayes, Seneca
Paper	Dr. H. L. Chambers, Lecompton
Paper,	Dr. J. A. Best, Centralia
Electro-therapeutics.....	Dr. U. G. Iles, Seneca
Hernia,	Dr. S. Murdock, Jr., Sabetha
Pott's disease, its etiology, pathology and diagnosis .....	.....
.....	Dr. J. R. Mains, Whiting
Notes on exophthalmic goiter	Dr. E. W. Reed, Holton

The Wilson County Medical Society met at Fredonia December 11. By special invitation Dr. L. D. Johnson, of Chanute, read a paper on "Some Phases of Abdominal Surgery." It was a masterly paper, and thoroughly enjoyed by those present. There still being time, Dr. Edwards of Chanute, read a paper on Tonsillitis, which was well received. The following officers were elected for the year 1907: Preston, Buffalo, president; Duncan, Fredonia, secretary and treasurer. Several applications were taken for membership. Next meeting will be at Fredonia, second Tuesday in February. J. L. HAYS, *Secretary*

Cowley County Medical Society met in regular session December 13, 1906, at Arkansas City. The following officers were elected:

President, Dr. J. H. Guinn, Arkansas City, Kan.

Vice President, Dr. Willis H. Hall, Winfield, Kan.

Treasurer, Dr. O. B. Wyant, Winfield, Kan.

Secretary, Dr. H. L. Snyder, Winfield, Kan.

The society has made a good gain for the year; nineteen new members were added.

The following resolutions were adopted:

WHEREAS, The members of the Cowley County Medical Society view with horror the many cases seen by them showing evidence of criminal operation; and whereas many people with the highest moral principles and pretending Christianity claim to think it perfectly right and free from danger to co-operate in the criminal work daily done; and whereas the act is not only a crime in the eyes of God and man, but is statutory crime punishable by penitentiary service and revoking of license of the operator and penitentiary service for those operated upon or those co-operating, and whereas the knowledge of the penalty of the great crime is viewed so lightly by the young as well as many in marital life; and whereas, the results of such criminal practice, is undermining the health of thousands, sending many to an untimely grave, is lowering the standing of the medical profession and degrading the morals of the younger generation.

Wherefore, be it resolved by the Cowley County Medical Society, in council assembled, that individually and collectively, we will do everything in our power to stop this deplorable practice, and further be it resolved, that this society offer a reward of \$100.00 for the arrest and conviction of any person or persons guilty of said crime and

Further be it resolved, that the secretary of the society furnish a copy of these resolutions to the Journal of the Kansas Medical Society for publication.

H. L. SNYDER, *Secy.*

Book Reviews.

Surgery: Its Principles and Practice. In five volumes, by 66 eminent surgeons. Edited by W. W. KEEN, M. D., L. L. D., Hon. F. R. C. S., Eng. and Edin., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Philadelphia. Cloth, \$7.00 per volume. W. B. SAUNDERS Co.

The first volume of this work, which is to consist of five volumes is just out. The other volumes are to follow at intervals of about three months. The first volume is octavo of 983 pages, with 261 text illustrations and 17 colored plates, and the list of names among the contributors comprise those most eminent in their lines today.

J. G. Mumford, Instructor of Surgery at Harvard, begins the work with a narrative of surgery: A Historical Sketch, which is interesting even from a lay point of view, but which from a medical view-point gives us a good sketch of prominent physicians from the time of Hippocrates to Lister.

George W. Crile, Professor of Clinical Surgery at Western Reserve, contributes the chapters on Surgical Physiology and wounds and contusions. Those who know of Crile's work on blood pressure, will be glad to learn that the gist of his experimental work, as it relates to surgical shock, is set down here. His is a work that is at the same time scientific and practical. John C. Da Costa, Jr., Associate in Clinical Medicine, Jefferson Medical College; hematologist to the German hospital, Philadelphia, contributes a chapter on Examination of the Blood, and treats his subject in relation to surgery. Ludwig Hektoen, Professor of Pathology in the University of Chicago, and Director of the Memorial Institute for Infectious Diseases, discusses Infection and Immunity. The cardinal conditions of infection are set down concisely and the question of immunity is presented in the plainest and most readily intelligible way that the writer has seen. J. G. Adami, Professor of Pathology at McGill, writes on Inflammation—certainly, on account of the "many diverse pictures of inflammation" a difficult subject. His definition is as follows: "Inflammation is the condition or series of conditions into which tissues enter as a reaction to irritation."

Leonard Freeman, Professor of Surgery, Denver and Gross Medical College of Medicine, follows with chapter on Suppuration, Abscess and Fistula, Ulceration and Ulcers, and Mortification and Gangrene. F. C. Wood, Professor of Clinical Pathology at the College of Physicians and Surgeons of Columbia University, contributes a very instructive chapter

on the Process of Repair. Not only are the general methods of repair considered, but also repair in the different organs and tissues. By far the largest contributor to this volume (from the point of view of the number of subjects), is C. H. Frazier, Professor of Clinical Surgery at the University of Pennsylvania. One chapter each is devoted to Thrombosis and Embolism, Erysipelas, Tetanus, diseases caused by Special Infections, Diseases Derived Directly from Animals, Insects and Reptiles and Scurvy. While some of the subjects are chiefly medical, they also have a surgical side and this is the side chiefly discussed, although the medical is by no means omitted. E. A. Smith, Adjunct Professor of Clinical Surgery of the University of Buffalo, devotes a chapter to the Traumatic Fevers. "The traumatic fevers are febrile conditions accompanied by definite symptom complexes which follow traumatisms anywhere to the body, whether infection of the contused or wounded area does or does not occur." Only traumatic aseptic or primary wound fever, septicaemia and pyaemia are considered as traumatic fevers. Rickets is discussed by E. H. Nichols, Assistant Professor of Surgical Pathology, Harvard Medical School. J. Chalmers Da Costa, Professor of the Principles of Surgery and Clinical Surgery at Jefferson Medical College, gives us the chapter on Surgical Tuberculosis which deals broadly with the subject from the historical to the discussion of tuberculosis of the different organs. Edward Martin, Professor of Clinical Surgery, University of Pennsylvania, writes the chapters on Chancroid and Syphilis. Chancroid is treated principally from a medical standpoint while Syphilis is as thoroughly treated as in most texts on skin diseases. J. Bland-Sutton, F. R. C. S., Eng., is the only foreign contributor to this volume. He devotes 144 pages to the discussion of tumors, which are divided into six groups—Tumor diseases of the connective tissues, tumor diseases of the teeth, epithelial tumors, tumors arising from the chorionic villi, teratoma and dermoids and cysts.

Each of these chapters is written by men especially qualified to discuss the subject and while it may be argued that such a method produces a disconnected book, one cannot say that it detracts any from the value. And the subjects, while briefly discussed, are complete. The necessity for conciseness is perhaps one of the advantages in such a volume as it does away with too much theoretical discussion and prolixity.

Another feature of the work is a complete bibliography following each subject. In the words of the editor, it is "Our aim to record the very latest, well-established, knowledge so that the work should be up-to-date, yet with few, if any, passing surgical novelties," and the reviewer believes it has done this and more.—S. C. E.

Grayson's Laryngology. The diseases of the Nose, Throat and Ear. By CHARLES P. GRAYSON, M. D., Clinical Professor of Laryngology, Medical Department, University of Pennsylvania. New (2d) edition, revised and enlarged. Octavo, about 550 pages, with 152 engravings and 15 plates in black and colors. Cloth, \$4.00, net. Lea Brothers & Co., Philadelphia and New York, 1906.

A medical student saw this volume lying on your reviewer's desk and proceeded to dip into it. He found it so interesting that he took the book home and returned it only with reluctance. "It reads so easily and is so instructive that I have learned a lot from it. It is just like Osler."

That student's opinion is quite our own. The author is perfectly sane and shows none of the radical tendencies and fads so often found in rhinolaryngologists. Lack of space prevents a detailed study of the book in this issue. This we hope to present that later,—but we hope that our readers will not hesitate to secure the book for themselves.

G. H. H.

The Practice of Gynecology, by W. EASTERLY, ASHTON, M.D., L. L. D., Professor of Gynecology in the Medico-Chirurgical College of Philadelphia. Third edition Thoroughly revised. Octavo, pp. 1096; 1057 original line drawings. W. B. Saunders & Co., 1906; cloth, \$6.50; half morocco, \$7.50.

It is worthy of note that this is the third edition of this work within a year; nothing could speak more forcibly as to the value of the work to students and practitioners.

A notable feature of the text is the number of illustrations all taken from original operations or apparatus. All told there are 1057 of them including illustrations of the instruments necessary in the various operations which is of undoubted aid to the young operator, or one who has not learned from hospital training just what instruments he is going to need. Another feature is the method in which the author approaches a subject. Instead of a general chapter on anatomy and diagnosis, by means of physical examination, he takes up the anatomy and the method of examination of each organ or part by itself, and then takes up its diseases and the treatment. And in the treatment—instead of confusing one with everyone's treatment he gives that one which he has found best, stating in addition those changes necessary to peculiar conditions and variations in the disease under discussion. But while the book represents the personality of the author it is not narrow as is seen by the advocacy of Dudley's method of operating for cystocele, Moynihan's method for intestinal anastomosis and others.

The details of treatment as well as of diagnosis are fully set forth and for the man who does not know it all, and wishes to learn, and for the occasional operator, these very details are the most valuable part

of the book. The author writes on the basis that the reader wishes the details and all of them. This idea carries itself into the consideration of diseases—even the urethral caruncle and adhesions of the clitoria are fully described and treated.

The chapter on the blood in its relation to surgery is a valuable one for the surgeon who has an assistant or an internist to make the necessary examinations. Even then there are few recent graduates who are qualified to make such examinations which perhaps accounts for the author's statement that "so far as surgical conditions are concerned, the blood findings are not pathognomonic in character and are too contradictory and conflicting to be relied upon as the sole means of making a positive diagnosis."

In the chapter on microscopical and bacteriological examinations, he gives careful instructions as to the manner of preserving and sending material to the pathologist so that it will arrive in good condition. The method of collecting correct findings is especially commended to the man who is tempted to swab out the uterus with a wad of cotton and send it to the pathologist asking an opinion relative to carcinoma.—S.C.E.

Diet in Health and Disease, by FRIEDENWALD & RUHRAH of the College of Physicians and Surgeons, Baltimore. Second edition, 1906. W. B. SAUNDERS Co. Cloth, pp. 728, price \$4.00.

The reviewer has used the first edition of this work for over a year and when in doubt about a certain article of diet or the proper feeding in a particular disease, has never failed to find at least a part of what he wished in this text.

The principles of diet are brought out so cleverly and the composition of various foods set down so concisely that one may readily select an extraordinary diet for a particular case. Not even the diet for athletes is neglected and the comparison between that of English and American athletes is interesting. The author in regard to alcohol states that it cannot be looked upon as a food tending to repair tissue, but merely as a fuel that on oxidizing, forms animal heat. Attention is also given to the feeding of infants and surgical cases, and the short account of the diet at some water cures which is given to all patients alike regardless of the disease is rather in the nature of censure.

The addition of the rapid reference diet lists in the new editions is a decided improvement over the first edition, in that it increases the convenience of the book for the busy physician.—S. C. E.

Golden Rules of Pediatrics, by JOHN ZAHORSKY, A. M., M. D., Clinical Professor of Pediatrics, Washington University, St. Louis, Mo. C. V. MOSBY Medical Book Publishing Co., St. Louis, Mo. Cloth, price \$3.00

This work will fill a vacant spot in the ordinary medical library, consisting as it does of terse statements and brief precepts. It cannot go into detail, but its use as a reference book will undoubtedly

put many of us on the right track in the diagnosis of the little patients presenting so few symptoms. Many new and valuable hints in approaching children, how to examine them without frightening them, and how to apply remedies with the least inconvenience are stated.

There are few of us who will not be enlightened by some such statement (and the book is full of them) as "Hutchinson's teeth indicating syphilis occur in the permanent teeth and not in the milk teeth."

The double index adds to the value of the book by making the contents more readily accessible. A single symptom can be quickly traced to the several diseases in which it occurs and by reference to the therapeutic index one quickly finds one or more methods of treatment for a particular ailment.—S. C. E.

Obstetrics for Nurses, by JOSEPH B. DELEE, M. D., Professor of Obstetrics in Northwestern University Medical School. 510 pages, fully illustrated; cloth, \$2.50 net. W. B. SAUNDERS CO.

From a physician's standpoint, this text seems almost ideal for the obstetrical nurse's guidance. The illustrations are numerous and good and comprise not only the arrangement of patient and bedding, but also convenient arrangement of tables and instruments are named and most of them illustrated for the principal operations which is useful to the physician as well as the nurse.

The diet for infants is given attention and a dietary for the mother which include not only the foods but how to prepare them.

The glossary of new words and terms completes a work which should be in the hands of every obstetrical nurse.—S. C. E.

Hirst's Text-book of Obstetrics, by BARTON COOKE HIRST, M. D., Professor of Obstetrics in the University of Pennsylvania. 899 pages, with 746 illustrations, 39 of them in colors. Cloth, \$5.00; sheep or half-morocco, \$6.00. W. B. SAUNDERS CO., Philadelphia.

"Hirst's" has been a standard for students and a guide for physicians for so long that mention need be made only of the most striking features of the fifth edition which is just out.

The first thing that attracts one's attention is the large number and the excellence of the illustrations. Many of these illustrations are from the author's cases and appear for the first time.

While disputed theoretical points are discussed enough to present different views and make them intelligible the book is not lumbered with such. In fact, the book is characterized by clear, concise statements and careful detail which combined with the illustrations, probably account for the popularity of the book.

In this edition more space has been devoted to the pathology of the puerperium and the diseases of the genital organs incident to childbirth. The one chapter on puerperal sepsis is worth the price of the book. This is a new chapter, and while one might not agree that a hysterectomy is advisable under septic conditions the reason for such an operation, under certain circumstances, advanced by the author, cause one to think that the hysterectomy with drainage is less dangerous than the unchecked septicemia especially when he cites cases where uterine douches produced harmful results.—S. C. E.

Prevalent Diseases of the Eye, by SAMUEL THEOBALD, M. D., Clinical Professor of Ophthalmology and Otology, Johns Hopkins University. 550 pages, 200 illustrations, 10 in colors, cloth, \$4.50 net. W. B. SAUNDERS CO.

This book is written for the general practitioner, assuming that he should be able to diagnose and treat more ocular diseases than he does without expecting him to become a specialist or take special training. It is rather novel in that the author, himself a specialist, should suggest that the physician should care for more of his eye cases, instead of sending them to the specialist.

The use of instruments difficult of manipulation, such as the ophthalmoscope, the consideration of such rare affections as those of the ciliary body and those diseases especially difficult of diagnosis or treatment, are omitted. They are more properly left for the consideration of the specialist. But those diseases of the anterior orbital parts (hordeolum, conjunctivitis, iritis, blepharitis marginalis) are considered in detail and in such a way, both as to diagnosis and treatment, as to be most useful to the man in general practice.—S. C. E.

Saunders' Pocket Medical Formulary. Eighth edition, flexible morocco, wallet and flap. W. B. SAUNDERS CO., \$1.75 net.

A very convenient pocket prescription book compiled by Wm. Powell, M. D., in accordance with the new pharmacopeia. Besides 1800 formulas, new and old, it has blank pages for the physician to set down individual prescriptions. There is a condensed table of poisons and their antidotes, a concise table of incompatibles and a posological table. Altogether a little book full of useful information especially for the younger generation of physicians whose training in prescription writing has been neglected.—S. C. E.

American Illustrated Dictionary. BY NEWMAN DORLAND, M. D. Red flexible leather binding, 836 pages. W. B. SAUNDERS CO. \$4.50 net; with thumb index \$5.

The book is printed on tough thin paper in small types so that while it is practically an unabridged dictionary it is convenient in size. The sub topics are readily found in a paragraph on account of the use of leaded type. The illustrations are excellent and there are 119 in colors. The type is small, as necessarily in a small volume, but plain. Obsolete terms and words are noticeable by their absence, while there are present all the new terms relative to immunity, which the general practitioner will doubtless find useful in his reading.—S. C. E.

Wanted—Partner. Town of 400. Must be a graduate, single, of good habits. Income moderate. Address Dr. H. M. Ochiltree, Had-dam, Kansas.

Nothnagel—8 Vols.—(1905)—absolutely new, for sale for \$25. Cost \$40. Write No. 42, care of THE JOURNAL, Rosedale, Kansas.

News and Notes.

Sixth International Dermatological Congress will be held Sept. 9 to 14, 1907, at the Academy of Medicine, 17 West Forty-third street, New York City. Membership costs \$5, but the meetings are open to the public. Abstracts of papers and registrations should be sent before May 1, to Dr. Jno A. Fordyce, secretary general, 80 West Fortieth street, New York City. The first congress of this kind met in Paris in 1889 and since that time, at intervals of about three years it has been held in Vienna, London, Paris and Berlin. At the Berlin meeting in 1904 New York was selected as the meeting place for 1907 and Dr. James C. White of Boston was elected president of the congress, the following organization committee having been appointed by him:

Dr. Chas. W. Allen* New York	Dr. W. S. Gottheil New York
Dr. John T. Bowen, Boston	Dr. Milton B. Hartzel . . Philadelphia
Dr. Andrew P. Biddle Detroit	Dr. James Nevins Hyde . . . Chicago
Dr. Edward B. Bronson . . . New York	Dr. George T. Jackson . . . New York
Dr. L. Duncan Bulkley . . . New York	Dr. Sigmund Lustgarten . . New York
Dr. R. R. Campbell Chicago	Dr. D. W. Montgomery . . San Francisco
Dr. Wm. T. Corlett Cleveland	Dr. Prince A. Morrow . . . New York
Dr. I. Dyer New Orleans	Dr. Wm. A. Pusey Chicago
Dr. George T. Elliott New York	Dr. Francis J. Shepherd . . Montreal
Dr. Martin F. Engman . . . , St. Louis	Dr. Grover W. Wendo Buffalo
Dr. John A. Fordyce New York	Dr. Henry W. Stelwagon . . Philadelphia
Dr. George Henry Fox New York	Dr. James W. Winfield . . Brooklyn
Dr. Thomas G. Gilchrist . . Baltimore	Dr. Joseph Ziesler Chicago

*Since deceased.

The themes offered for discussion are:

I. THE ETIOLOGICAL RELATIONSHIP OF ORGANISMS FOUND IN THE SKIN IN EXANTHEMATA.

To be presented by Prof. W. T. Councilman, Boston.

To be discussed by Prof. Gary M. Calkins, New York.

II. TROPICAL DISEASES OF THE SKIN.

To be presented by Dr. H. Radcliffe-Crocker, London, England; Prof. G. Riehl, Vienna, Austria; Dr. William Dubreuilh, Bordeaux, France; Dr. W. H. Brinkerhoff, Honolulu; Dr. J. H. Wright, Boston.

To be discussed by Dr. C. W. Stiles, Washington, D. C.; Dr. Baldo-mero Sommer, Buenos Ayres, S. A.

III. A. THE POSSIBILITY OF IMMUNIZATION AGAINST SYPHILIS.

To be presented by Prof. A. Neisser, Breslau, Germany; Prof. Ernest Finger, Vienna, Austria; Dr. L. E. Leredde, Paris, France.

To be discussed by Prof. T. de Amicis, Naples, Italy.

III. B. THE PRESENT STATUS OF OUR KNOWLEDGE OF THE PARASITOLOGY OF SYPHILIS.

To be presented by Erich Hoffman, Berlin, Germany.

To be discussed by Dr. A. Buschke, Berlin, Germany; Dr. K. Herxheimer, Frankfort, a. m., Germany.

Vital Statistics:

As secretary of the Elk county society I have received a pamphlet and a copy of resolutions passed by the American Medical Association for the purpose of calling attention to the interest of vital statistics of the several states of our union, asking the cooperation of medical societies and physicians to the importance of a move for uniform method in registration of births and deaths. Either the laws of some of the states are inadequate, ambiguous, or the incentive to furnish certificates by those whose duty it is, would seem to be among the reasons for the present deplorable conditions. The pamphlet referred to emanates from the office of vital statistics at Washington, and gives the laws of Pennsylvania on this subject with special reference to registration of births and deaths as passed by the Pennsylvania legislature in 1905. It seems from a casual reading the law is a good one, but encumbered with some features that might be improved. The law, of course, is under the state board of health. It provides for a state registrar, who shall be a physician at a salary of \$2,500, with adequate assistants and the state is divided into districts each of which shall have a registrar, who shall receive a compensation of 25 cents for each certificate of birth or death recorded. From every family where a birth or death occurs a letter of notification shall be sent to the registrar stating the fact.

The physician in attendance must make the certificate of birth or death without cost. A failure to furnish the certificate shall be deemed a misdemeanor subject to a fine.

No class of persons has a greater interest in vital statistics than the physicians, and we are supposed to take enough interest in that subject to make all returns accurately and promptly. But experience proves the contrary, i. e., that there are many physicians who say the state has no right to take my time to write a certificate and spend my money in sending that certificate to the proper authorities. And while there is a law in this state and perhaps all the others, with a penalty for neglecting this duty, it is constantly no doubt being neglected. I believe the difficul-

ty could be obviated by paying the physicians a reasonable compensation, say, 25 cents for each certificate made by him where he has attended the case in person, or in a case where no legally authorized person was in attendance. The same law should obtain as in Pennsylvania with reference to notifying the proper authority of each birth and death, so that a tally would be kept by the county health officer. These views met the approval of our society, and the following resolutions were passed:

Whereas, the vital statistics with reference to registration of births and deaths have not been and are not now given as accurately and promptly as the present law contemplates, and **whereas** physicians are the most interested and the best adapted to give such statistics, and

Whereas, the law of compensation for labor applies to physicians as well as others. Therefore be it

Resolved, that it is the sense of the Elk County Medical society, that the Legislature of Kansas be asked to pass an amended law on vital statistics as applied to registration of births and deaths, similar to the laws on that subject as now exist in the state of Pennsylvania. except that instead of the state being divided into districts, that each physician in the state qualified under the laws to practice medicine shall act as local registrar and for such service as making certificates of births and deaths whether in his own practice, or where there was no physician in attendance lawfully competent to make certificates he shall receive for each certificate the sum of 25 cents. This fee should be paid from the county funds where the birth or death occurs.

Howard, Kansas.

J. L. HAYS.

IN MEMORIAM.

DR. L. A. BUCK.

After the funeral of Dr. L. A. Buck of Peabody the Marion County Medical society, a large majority of whose members had been in attendance; convened for the purpose of conferring on this, the first death of a member since its organization. After a number of individual members had expressed their grief and feeling of personal loss by Dr. Buck's deplorable death, a committee was appointed to prepare appropriate resolutions for publication. This committee offers the following:

Whereas the Marion County Medical Society has been called together for the mournful purpose of expressing by the presence of its members, and by such words as it may find, the sorrow which can never be adequately expressed in language, but which custom and a desire to offer tribute by utterance has established, we present the following resolutions on the lamentable death of its foremost member, Dr. L. A. Buck: That this society unanimously voices its sincere sorrow over the grave of its beloved brother and esteemed member, Dr. L. A. Buck;

That the society as a whole and each member as an individual consider Dr. Buck's future absence from our meetings an irreparable loss to the scientific and progressive aims of our society and a still greater void will be felt by each one of us who had become accustomed to his cheery welcome and genuine and warm hand-shake.

Resolved that not only has the medical profession and this society sustained a great loss in the passing away of Dr. Buck, but that his patients and patrons will long lament his absence from their bedsides of suffering where his cheering, encouraging ways and words carried hope and ease; and from his office where many went in with drooping, despondent heads to come out with cleared eyes and a brighter outlook on the future.

Resolved that to his stricken family we offer our deepest, heartfelt sympathy for a sorrow which words cannot lift but which we can humbly present with the feeling of assurance that they will meet their loved and lost one in a longer or shorter interval as the court of human time goes but a second of eternity in the happier hereafter.

Signed { G. P. MARNER,
J. WERTHNER,
R. C. SMITH.

Memorial—We were very much shocked Friday morning, December 13, 1906, when a telegram was received announcing the death of Doctor Buck. He had been to Hot Springs to attend a meeting of the Rock Island railroad surgeons, and was taken sick on the train homeward bound. He was removed to the Rock Island hospital at El Reno, Okla., where he was from Saturday, December 8, until death claimed him. Our memories of Doctor Buck are of his kind and happy character. We of this society who have been associated with him in his profession will miss him exceedingly and will always remember his "Happy, happy, always happy" to our greeting, How are you doctor? When called in council, or asked for advice it was always carefully given, and in no uncertain manner, as it was acquired by a studious and a long professional career, having practiced medicine for thirty years. We will miss him from our meetings, as he was always enthusiastic in the discussion of our papers, on any subject brought before the society. We cannot help but extend our sympathy to his family and the community; the one has lost a husband and father, the other a worthy citizen. At a meeting of the Peabody Academy of Medicine it was resolved that the above mentioned memorial is in accord to our feelings and that a copy be sent to the family of the deceased, our local paper and the Kansas State Medical Journal.

O. J. FURST,

J. M. S. CHESHIRE

E. H. JOHNSON

H. M. MAYER

Committee.

REPORT OF THE COUNCIL ON PHARMACY AND CHEMISTRY.

We reprint herewith from The Journal of the American Medical Association, for September 15, the first installment of the report of the Council on Pharmacy and Chemistry. Additional installments will appear from time to time. The importance of these reports is too evident to need comment. For the first time in the history of the organized profession, a scientific commission, whose ability and probity is above suspicion, has reported on preparations regarding which heretofore we have had only the report of those interested, financially and otherwise, in their exploitation.

ACETOZONE.

A mixture of equal parts of benzoylacetyl peroxide and an inert absorbent powder.

Actions and Uses.—Benzoylacetyl peroxide belongs to a class of compounds known as the organic peroxides in which an excess of oxygen has been combined in such a way that it is somewhat slowly given off in a nascent condition. On contact with water it hydrolyzes, forming benzo-peracid and aceto-peracid which exert marked oxidizing and germicidal action. In consequence of this change, these compounds are thought to be particularly adapted for internal administration. The germicidal and antiseptic properties of this substance have been attested by the experimental results of several observers. It has been used in ophthalmic, aural and nasal practice with asserted good effects as an antiseptic. It has also been applied internally, especially in typhoid fever, with a view to the disinfection of the intestinal canal, and appears to be an intestinal antiseptic. **Dosage.**—Acetozone is generally employed in aqueous solution prepared as follows: Add acetozone to warm water in the proportion of 1 Gm. to 1000 Cc. (15 grains to the quart). Shake vigorously for five minutes, and allow to stand for about two hours. Decant the liquor as required. This solution may be drunk ad libitum, two quarts or more being taken by an adult in twenty-four hours. Acetozone is also used in oily solution as an inhalant. Manufactured by Parke, Davis & Co., Detroit, Mich.

ACETOZONE INHALANT.

A solution of benzoylacetyl peroxide in liquid petrolatum. **Formula.** One hundred grammes contain: Benzoylacetyl peroxide, 1.0 Gm.; chloreton (chlorbutanol), 0.5 Gm.; Refined liquid petrolatum, 98.5 Gm.

Dosage.—It is to be inhaled in the form of a very fine spray, or nebula best produced by an atomizer especially designed for oily liquids. Prepared by Parke, Davis & Co., Detroit, Mich.

ACET-THEOCINSODIUM.

Acet-theocinsodium, $C_7H_7N_4O_2Na \cdot CH_3COONa$, a double salt of sodium acetate and 1.3 dimethylxanthine-sodium (theophyllinsodium).

Actions and Uses.—It has the diuretic properties of theocin, reinforced by the diuretic action of sodium acetate, and, being more soluble, it has been claimed to be more readily absorbed and better tolerated than theophylline. It is recommended in cardiac affections, nephritis, dropsy, etc. **Dosage.**—0.22 to 0.35 Gm. (3 to 5 grains) best given after meals. Manufactured by Farbenfabriken vorm. Friedr. Bayer & Co., Elberfeld, Germany, Continental Color and Chemical Co., New York).

ADNEPHRIN EMOLLIENT.

Recommended as a local application where prolonged use is required. Prepared by F. Stearns & Co., Detroit, Mich.

ADNEPHRIN OIL SPRAY.

The preparation is applied as a spray to the mucous membranes in congestive and inflammatory affections, preferably after washing with Dobell's solution. Prepared by F. Stearns & Co., Detroit Mich.

ADNEPHRIN SOLUTION.

A sterile solution 1-1000 of the suprarenal active principle in physiologic salt solution containing one-half of one per cent of methaform (chlorbutanol).

Actions and Uses.—The actions and uses of this preparation are described under Suprarenal Alkaloid. Dosage.—The dose internally is from 0.2 to 2.0 Cc. (3 to 30 minims) in water. Adnephtrin is also used in oily solution as a spray, see Adnephtrin Oil Spray, and in the form of ointment, see Adnephtrin Emollient. Prepared by F. Stearns & Co., Detroit, Mich.

ADRENALIN.

The active alkaloid of suprarenal gland, prepared by the method of Takamine, see Suprarenal Alkaloid.

Dosage.—Locally, 1-1000 to 1-15000 solution, as the chloride. Internally, 0.3 to 2 Cc. (5 to 30 mm.) of 1-1000 solution. Hypodermically, 1 to 15 drops of 1-1000 solution, diluted with sterile water. Manufactured by Parke, Davis & Co., Detroit, Mich.

ADRENALIN CHLORIDE SOLUTION.

Dosage.—See adrenalin. Prepared by Parke, Davis & Co., Detroit, Michigan.

ADRENALIN SUPPOSITORIES.

I part of the adrenalin to 1000 parts of oil of theobroma (cocoa butter). Each suppository weighs about 1 Gm. (15 grains). Prepared by Parke, Davis & Co., Detroit, Mich.

AGURIN.

Agurin, $C_7H_7N_4^+O_2Na + NaC_2H_3O_2$, a double salt of sodium acetate and theobromine-sodium.

Actions and Uses.—It acts like theobromine over which it has the advantage of great solubility and that it is well tolerated by the stomach. While inferior in diuretic power to theophyllin (which see), it is said to have greater power in sustaining the diuresis produced. Dosage.—0.5 to 1 Gm. (7 to 15 grains), preferably in wafers or capsules. If in solution, this should be freshly prepared (with peppermint water) and without sugar or mucilage. Manufactured by Farbenfabriken vorm. Friedr. Bayer & Co., Elberfeld, Germany (Continental Color and Chemical Co., New York).

AIROL.

Airol, $C_6H_2(OH)_3(COOBi(OH)) = C_7H_6O_6IBi$, a combination of bismuth oxyiodide (subiodide) and gallic acid.

Actions and Uses.—As it liberates iodine in the nascent state in the presence of wound secretions it has been recommended as a desirable and efficient substitute for iodoform in the treatment of wounds, burns, skin diseases, gonorrhea, etc. Dosage.—It is used externally in the pure state or diluted with talc, or in the form of a 10 per cent suspension in equal parts of glycerin and water, or as a 10 to 20 per cent. ointment with 2 parts of petrolatum and 7 parts of wool fat. Manufactured by F. Hoffman-LaRoche & Cie., Basle, Switzerland (The Hoffman-LaRoche Chemical Works, New York).

ALPHA-EUCAINE HYDROCHLORIDE.

Alpha-eucaine hydrochloride is the hydrochloride of benzoyl-methyl-oxypiperidine-carbonic methyl ester.

Actions and Uses.—The action of alpha-eucaine is similar to that of cocaine, but it is regarded as three and three-fourths times less toxic than cocaine. In large doses it first stimulates and then paralyzes the central nervous system; it slows the heart and produces a fall of blood pressure. Locally it acts like cocaine as an anesthetic but dilates the blood vessels instead of contracting them. It does not dilate the pupil. It is more irritating to the mucous membrane than cocaine or than beta-eucaine. It has a moderate bactericidal action. It is used as a substitute for cocaine in general and minor surgery but beta-eucaine is preferred for applications to the eye. **Dosage.**—2 to 5 or even 9 per cent. solutions. Not more than 2 Cc. (30 minims) of a 4 per cent. solution should be used at one time. Manufactured by Chemische Fabrik auf Actien. vorm. E. Schering, Berlin (Schering & Glatz, New York).

ALPHOZONE.

Alphozone. $(\text{COOH}.\text{CH}_2\text{CH}_2\text{CO})_2\text{O}_2-\text{C}_8\text{H}_{10}\text{O}_8$, an organic peroxide resulting from the action of hydrogen dioxide on succinic anhydride.

Actions and Uses.—Alphozone belongs to the class of organic peroxides, and by its powerful oxidizing power becomes a germicide and antiseptic. **Dosage.**—Alphozone is also marketed in the form of tablets containing each 0.065 Gm. (1 gr) of alphozone, which are used for making solutions, one tablet to 60 Cc. (2 fluid ounces) of water giving a solution (1 to 1000) suitable for general external use; but, as a nasal douche, one tablet in 180 Cc. (6 fluid ounces) of water is often preferred. Manufactured by F. Stearns & Co., Detroit, Mich.

ALUMNOL.

The aluminium salt of B-naphtholdisulphonic acid, $\text{Al}_2(\text{C}_{10}\text{H}_5.\text{OH}.\text{(SO}_3)_2)=\text{Al}_2\text{C}_{30}\text{H}_{18}\text{O}_{21}\text{S}_6$.

Actions and Uses.—It is an astringent and mild antiseptic. It is claimed that it can be used as a mild astringent, an irritant or a caustic, according to the strength of the solution, and it is asserted that it exerts a peculiarly destructive action on gonococci. It has been recommended for a variety of affections in which a caustic, astringent or antiseptic is indicated. It has been particularly recommended for gonorrhea in females, especially when affecting the endometrium. **Dosage.**—As a surgical antiseptic, in 0.5 to 3 per cent. solution; in gynecology, in 2 to 5 per cent. solutions; in otology and laryngology, either as powder or in $\frac{1}{4}$ to 1 per cent. solution as douches washes or gargles; as cautery, in 10 to 20 per cent. solution. Manufactured by Farbwerke vorm. Meister, Lucius & Bruening, Hoechst a. M. (Victor Koechl & Co., New York).

AMINCFORM.

A name applied to Hexamethylenamina, U. S. P., Sold by C. Bischoff & Co., New York.

ANESTHESIN.

Anesthesin. $\text{C}_6\text{H}_4(\text{NH}_2)(\text{COOC}_2\text{H}_5)$ 1:4— $\text{C}_9\text{H}_{11}\text{O}_2\text{N}$ the ethylester of paramido-benzoic acid, obtained by the reduction of paranitrobenzoic acid.

Actions and Uses.—It was introduced as a substitute for cocaine and is a local anesthetic, similar in its action to orthoform and said to be equally effective, but free from irritant action and toxicity. The anesthetic action, like that of the related compound orthoform, resembles that of cocaine, but is purely local, does not penetrate the mucous membranes and in consequence of its insolubility the compound can not be used by hypodermic injection. In consequence of its insolubility the anesthetic effect is more prolonged than that of cocaine. It is recommended in various forms of gastralgia, in ulcer and cancer of the stomach, for the relief of pain, and is applied locally in rhinologic and laryngeal affections, urethritis, etc.; it is also recommended for anesthetizing wounded surfaces, burns, ulcerations and painful affections of the

skin. It is more effective in cases where the skin is broken. Dosage.—Internally, 0.3 to 0.5 Gm. (5 to 8 grs.) in pastilles. Externally it is applied as a dusting powder, either pure or diluted. It may be applied as an ointment or in the form of suppositories. Manufactured by Farbwerke, vorm. Meister, Lucius & Bruening, Hoechst a. M. (Victor Koechl & Co., New York).

ANTIPYRINE SALICYLATE.

Antipyrine salicylate, $C_{11}H_{12}N_2O.C_6H_4OH.COOH=C_{18}H_{18}N_2O_4$, a weak chemical combination of antipyrine and salicylic acid.

Actions and Uses.—This compound possesses the properties of both antipyrin and salicylic acid and combines the analgesic power of the one with the anti-rheumatic action of the other. It has been used with good results in sciatica, rheumatic fevers, chronic rheumatism, influenza, pleurisy, dysmenorrhea, etc. Dosage.—0.3 to 2.0 Gm. (5 to 30 grains) in cachets or capsules.

ANTITHERMOLINE.

A name applied to a preparation said to be made according to the following formula: Each pound contains 4000 grains of imported washed kaolin, washed and purified, 14 grains boric acid, 14 grains oil of eucalyptus, menthol and thymol combined, and 4.9 fluid ounces of glycerin. It closely resembles the Cataplasma Kaolini, U. S. P. Prepared by G. W. Carnrick Co., New York.

ANTITHYROID PREPARATIONS.

Preparations obtained from the blood or milk of animals, after the removal of the thyroid glands. The use of these preparations is based on the theory that the thyroid gland secretes products which are toxic, but which neutralize, and are neutralized by other toxic substances produced elsewhere in the body. Removal of the thyroid glands, therefore, leads to the accumulation of these second toxic substances as evidenced by the phenomena of cachexia strumipriva and myxedema. On the other hand, the blood or milk of such animals is capable of preventing the effects of a hypersecretion of thyroid substance, such as is supposed to occur in Basedow's disease (exophthalmic goiter). These views are still largely hypothetical; but the majority of clinical observers report markedly beneficial results in the milder forms of the disease and in obscure nervous disorders which are supposedly connected with thyroid hypersecretion. The effects are less pronounced in the more severe forms. The action is merely palliative and other measures of treatment should not be neglected. Improvement occurs in two or three weeks and is indicated by an amelioration of the nervous symptoms, tremors, palpitation, insomnia and excitability. The administration must be long continued. Oral and hypodermic administration are equally effective, but the former is usually preferred. These preparations are not toxic, even when very large doses are used.

ANT THYROIDIN MOEBIUS.

The blood serum of sheep from which the thyroid gland has been removed at least six weeks before the blood is drawn, preserved by the addition of 0.5 per cent. of phenol.

Actions and Uses.—For actions and uses see Antithyroid Preparations. Dosage.—It is administered by the mouth in doses beginning with 0.5 to 1 Cc, (8 to 15 min.) three times a day, gradually increasing the dose as necessary. Manufactured by E. Merck, Darmstadt. (Merck & Co., New York).

ARGENTAMIN.

An aqueous solution of silver nitrate and ethylenediamine, corresponding to 10 per cent of silver nitrate.

Actions and Uses.—It is antiseptic and astringent like other silver salts, with the asserted advantage of being non-irritant and more penetrating than silver nitrate.

It is said to be useful in all cases where the non-caustic action of silver nitrate is indicated. Dosage.—It may be used in the anterior urethra in 0.25 to 1 per cent. solution; in the posterior urethra in from 1 to 4 per ct. solution; in ophthalmology in 5 per cent solution. Manufactured by Chemische Fabrik auf Actien, vorm. E. Schering, Berlin. (Schering & Glatz, New York)

ARGONIN.

A soluble casein compound containing 4.28 per cent. of silver.

Actions and Uses.—Its action and uses are similar to those of silver nitrate, but it is claimed to have greater power of permeating living colloid membranes than other silver albumoses. It is applied as an injection in 0.1 to 0.2 per cent. solution; in ophthalmic practice a 10 to 20 per cent. solution in glycerin may be used. Dosage.—It is generally used in 0.5 per cent. solution, but even 20 per cent. solutions have been injected without producing irritant symptoms. Manufactured by Farbwerke vorm. Meister, Lucius & Bruening, Hoechst a. M. (Victor Koechl & Co., New York).

ARGYROL.

A compound of a derived proteid and silver oxide, containing from 20 to 25 per cent. of silver.

Actions and Uses.—Solutions of argyrol (20 to 50 per cent.) are said to be non-irritating to mucous membranes. Taken internally it is said to be non-toxic. It is claimed to be an antiseptic. It is recommended in urethritis and cystitis, in conjunctivitis and in affections of the nose, throat and ear. Dosage.—It is employed in from 10 to 25 per cent. and even stronger solutions. Manufactured by Barnes & Hille, Philadelphia.

NEW AND NON-OFFICIAL REMEDIES.

The following articles have been tentatively approved by the Council on Pharmacy and Chemistry of the American Medical Association. The list will be revised by adding other articles as accepted and by omitting any which on further investigation may be found to conflict with the rules of the Council.

Following the name of each article is the name of the manufacturer, or, in case of foreign products, of the American agent; where no name is given the article is believed to be neither protected by patent nor trademark. The date following the article prefers to the preliminary publication in The Journal A. M. A. When no date is given, the description has not yet been published.

Acetozone (P. D. & Co.), Sept. 15, 1906.	Adnephryn Suppositories (Stearns & Co.).
Acetozone Inhalant (P. D. & Co.), Sept. 15, 1906.	Adrenalin (P. D. & Co.), Sept. 15, 1906.
Acet-theocinsodium (Cont. Color and Chem. Co.), Sept. 15, 1906.	Adrenalin Chloride Solution (P. D. & Co.), Sept. 15, 1906.
Adnephryn Emollient (Stearns & Co.), Sept. 15, 1906.	Adrenalin Suppositories (P. D. & Co.), Sept. 15, 1906.
Adnephryn Oil Spray (Stearns & Co.), Sept. 15, 1906.	Agurin (Cont. Color & Chem. Co.), Sept. 15, 1906.
Adnephryn Solution (Stearns & Co.), Sept. 15, 1906.	Airol (Hoffman-La Roche Chem. Works), Sept. 15, 1906.
	Albargin (Koechl & Co.).

- Alpha-Eucaine Hydrochloride (Schering & G.), Sept. 15, 1906.
Alphozone (Stearns & Co.), Sept. 15, 1906.
Alphozone Tablets (Stearns & Co.), Sept. 15, 1906.
Alumol (Koechl & Co.), Sept. 15, 1906.
Alypin (Cont. Color & Chem. Co.).
Aminoform (Bischoff & Co.), Sept. 15, 1906.
Anesthesin (Koechl & Co.), Sept. 15, 1906.
Anthrasol (Knoll & Co.).
Antipyrine Salicylate, Sept. 15, 1906.
Antithermoline, (G. W. Carnrick Co.), Sept. 15, 1906.
Antithyroidin (Merck & Co.), Sept. 15, 1906.
Antithyroid Preparations, Sept. 15, 1906.
Argentamin, (Schering & G.), Sept. 15, 1906.
Argonin (Koechl & Co.), Sept. 15, 1906.
Argyrol (Barnes & Hille), Sept. 15, 1906.
Aristochin (Cont. Color & Chem. Co.), Sept. 22, 1906.
Aristol (Cont. Color & Chem. Co.), Sept. 22, 1906.
Aspirin (Cont. Color & Chem. Co.), Sept. 22, 1906.
Benzosol (Koechl & Co.), Sept. 22, 1906.
Beta-Eucaine Hydrochloride (Schering & G.), Sept. 22, 1906.
Beta-Naphthol Benzoate (Merck & Co.), Sept. 22, 1906.
Betol (Heyden Chem. Works), Sept. 22, 1906.
Bismal (Merck & Co.), Sept. 22, 1906.
Borochloretone (P. D. & Co.), Sept. 22, 1906.
Brometone (P. D. & Co.), Sept. 22, 1906.
Bromipin—10 per cent. (Merck & Co.) Sept. 29, 1906.
Bromipin—33 1-3 per cent. (Merck & Co.), Sept. 29, 1906.
Butyl-Chloralhydrate Sept. 29, 1906.
Calcium Ichthyol (Merck & Co.), Sept. 29, 1906.
Calomelol (Heyden Chem. Works), Sept. 29, 1906.
Calomelol Ointment (Heyden Chem. Works), Sept. 29, 1906.
Cascara Evacuant (P. D. & Co.), Sept. 29, 1906.
Cascara Tonic Laxative Globules (P. D. & Co.), Sept. 29, 1906.
Chinaphenin (Cont. Color & Chem. Co.), Sept. 29, 1906.
Chloralamid (Schering & G.).
Chlorbutanol, Sept. 29, 1906.
Chloretone (P. D. & Co.), Sept. 29, 1906.
Chloretone Inhalant (P. D. & Co.), Sept. 29, 1906.
Citarin (Cont. Color & Chem. Co.), Sept. 29, 1906.
Collargol (Schering & G.).
Collargol Ointment (Schering & G.).
Cresotal (Cont. Color & Chem. Co.), Oct. 6, 1906.
Cresylone, (P. D. & Co.).
Cupro-Hemol (Merck & Co.).
Dentalone (P. D. & Co.), Oct. 6, 1906.
Dermatol (Koechl & Co.), Oct. 6, 1906.
Diabetin (Schering & Co.), Oct. 6, 1906.
Dionin (Merck & Co.), Oct. 6, 1906.
Diuretin (Merck & Co.), Oct. 6, 1906.
Duotal (Cont. Color & Chem. Co.), Oct. 6, 1906.
Duotonal (Schering & G.), Oct. 6, 1906.
Elixir Eupnein (Schieffelin & Co.), Oct. 6, 1906.
Elixir Saw Palmetto (P. D. & Co.), Oct. 6, 1906.
Empyroform (Schering & G.), Oct. 6, 1906.
Epicarin (Cont. Color & Chem. Co.), Oct. 6, 1906.
Erythrol Tetranitrate (Merck & Co.), Oct. 6, 1906.
Ethylenediamine (Schering & G.), Oct. 6, 1906.
Eucaïne, Oct. 6, 1906.
Eucaloids (Edward G. Binz), Oct. 6, 1906.
Eucamol (Edward G. Binz), Oct. 13, 1906.
Euformol (P. D. & Co.)
Eugallol (Knoll & Co.), Oct. 13, 1906.
Eumydrin (Cont. Color & Chem. Co.), Oct. 13, 1906.
Euphorin (Fbrk. v. Heyden), Oct. 13, 1906.
Euphthalmin (Schering & G.), Oct. 13, 1906.
Euquinine (Merck & Co.), Oct. 13, 1906.
Euresol (Knoll & Co.), Oct. 13, 1906.
Euresol Soap (Knoll & Co.), Oct. 13, 1906.
Europhen (Cont. Color & Chem. Co.), Oct. 13, 1906.

- Exodin (Schering & G.).
 Ferrichthyl (Merck & Co.), Oct. 13, 1906.
 Ferripyryne (Koechl & Co.), Oct. 13, 1906.
 Ferropyryne (Knoll & Co.), Oct. 13, 1906.
 Formalin (Schering & G.), Oct. 13, 1906.
 Formin (Merck & Co.), Oct. 13, 1906.
 Gallogen (Bischoff & Co.), Oct. 13, 1906.
 Germicidal Soap (P. D. & Co.), Oct. 13, 1906.
 Glutol-Schleich (Schering & G.), Oct. 13, 1906.
 Glycerin Emollient (P. D. & Co.), Oct. 13, 1906.
 Glycerophosphates, Oct. 13, 1906.
 Guaiacol-Salol (Merck & Co.), Oct. 13, 1906.
 Guaiamar (Mallinckrodt Chem. Works), Oct. 20, 1906.
 Guajasanol (Koechl & Co.), Oct. 20, 1906.
 Haemoferrum (Stearns & Co.)
 Hedonal (Cont. Color & Chem Co.), Oct. 20, 1906.
 Helmitol (Cont. Color & Chem Co.), Oct. 20, 1906.
 Hemicranin (Cont. Color & Chem. Co.), Oct. 20, 1906.
 Hemogallol (Merck & Co.), Oct. 20, 1906.
 Hemol (Merck & Co.).
 Hemoquinine (Schieffelin & Co.), Oct. 20, 1906.
 Heroin (Cont. Color & Chem. Co.), Oct. 20, 1906.
 Heroin Hydrochloride (Cont. Color & Chem. Co.), Oct. 20, 1906.
 Heromal (Schieffelin & Co.), Oct. 20, 1906.
 Heroterpine (Schieffelin & Co.), Oct. 20, 1906.
 Hetol (Merck & Co.), Oct. 20, 1906.
 Hexamethylenamine Methylencitrate, Oct. 27, 1906.
 Holocaine Hydrochloride (Koechl & Co.), Oct. 27, 1906.
 Hypnal (Koechl & Co.), Oct. 27, 1906.
 Ichthalbin (Knoll & Co.), Oct. 27, 1906, Nov. 10, 1905.
 Ichthammon (F. Reichelt), Oct. 27, 1906.
 Ichthargan (Ichthyl Co.), Oct. 27, 1906.
 Ichthermol (Merck & Co.), Oct. 27, 1906.
 Ichthoform (Merck & Co.), Oct. 27, 1906.
 Ichthyl (Merck & Co.), Oct. 27, 1906.
 Ichthyolum Austriacum (G. Heil & Co.), Oct. 27, 1906.
 Iodipin—10 per cent. (Merck & Co.), Oct. 27, 1906.
 Iodipin—25 per cent. (Merck & Co.), Nov. 3, 1906.
 Iodoformogen (Knoll & Co.), Nov. 3, 1906.
 Iodothyryne (Cont. Color & Chem. Co.), Nov. 3, 1906.
 Iothion (Cont. Color & Chem. Co.), Nov. 3, 1906.
 Isoform Powder (Koechl & Co.), Nov. 3, 1906.
 Isopral (Cont. Color & Chem. Co.), Nov. 3, 1906.
 Kasagra (Stearns & Co.), Nov. 3, 1906.
 Kola, Stearns, (Stearns & Co.), Nov. 3, 1906.
 Kresamine (Schering & G.), Nov. 3, 1906.
 Lac Bismo (E. J. Hart & Co.), Nov. 3, 1906.
 Lactophenin (Chem. Fbrk. vrm., Goldenberg, Geromont & Co.), Nov. 3, 1906.
 Laminoids Ferruginous (Nascent) (Schieffelin & Co.), Nov. 3, 1906.
 Lennigallol (Knoll & Co.), Nov. 3, 1906.
 Liquor Tritici (P. D. & Co.), Nov. 3, 1906.
 Lithium Ichthyl (Merck & Co.), Nov. 3, 1906.
 Lycetol (Cont. Color & Chem. Co.), Nov. 3, 1906.
 Lysidin (Koechl & Co.), Nov. 3, 1906.
 Mercurol (P. D. & Co.), Nov. 3, 1906.
 Mesotan (Cont. Color & Chem. Co.), Nov. 3, 1906.
 Methaform (Stearns & Co.), Nov. 3, 1906.
 Migrainin (Koechl & Co.), Nov. 3, 1906.
 Neurocaine (Schieffelin & Co.), Nov. 3, 1906.
 Neuronidia (Schieffelin & Co.), Nov. 3, 1906.
 Novargan (Heyden Chem. Works).
 Novocaine (Koechl & Co.), Nov. 10, 1906.
 Nutrose (Koechl & Co.), Nov. 3, 1906.
 Oil of Eucalyptus, globules (E. G. Binz).
 Organic Iron Preparations.
 Orthoform-New (Koechl & Co.), Nov. 10, 1906.
 Orthoform-New Hydrochloride (Koechl & Co.), Nov. 10, 1906.

- Ovoferrin (Barnes & Hille) Nov. 10, 1906.
 Oxaphor (Koechl & Co.), Nov. 10, 1906.
 Pegnin (Koechl & Co.), Nov. 17, 1906.
 Phenacetin (Cont. Color & Chem. Co.), Nov. 10, 1906.
 Phenocoll Hydrochloride (Schering & G.), Nov. 10, 1906.
 Phenocoll Salicylate, Nov. 10, 1906.
 Piperazine (Cont. Color & Chem. Co., Schering & G.), Nov. 17, 1906.
 Pollantin (Fritzsche Bros.), Nov. 17, 1906.
 Pollantin Powder (Fritzsche Bros.), Nov. 17, 1906.
 Protargol (Cont. Color & Chem. Co.), Purgatin (Knoll & Co.), Nov. 17, 1906.
 Pyramidon (Koechl & Co.), Nov. 17, 1906.
 Pyramidon Neutral Camphorate (Koechl & Co.), Nov. 17, 1906.
 Pyramidon Acid Camphorate (Koechl & Co.), Nov. 17, 1906.
 Pyramidon Salicylate (Koechl & Co.), Nov. 17, 1906.
 Quartonal (Schering & G.), Nov. 24, 1906.
 Red Bone Marrow (Armour & Co.).
 Sajodin (Cont. Color & Chem. Co.).
 Sal Ethyl (P. D. & Co.), Nov. 24, 1906.
 Saliformin (Merck & Co.), Nov. 24, 1906.
 Salit (Heyden Chem. Works), Nov. 24, 1906.
 Salophen (Cont. Color & Chem. Co.), Nov. 24, 1906.
 Saloquinine (Merck & Co.), Nov. 24, 1906.
 Saloquinine Salicylate (Merck & Co.), Nov. 24, 1906.
 Santyl (Knoll & Co.).
 Sextonol (Schering & Co.), Nov. 24, 1906.
 Sidonal (Koechl & Co.), Nov. 24, 1906.
 Sodium Cacodylate, Nov. 24, 1906.
 Sodium Cinnamate, Nov. 24, 1906.
 Sodium Ichthyol (Merck & Co.), Dec. 1, 1906.
 Stovaine (Walter F. Sykes), Dec. 1, 1906.
 Stypticin (Merck & Co.), Dec. 1, 1906.
 Styptol (Knoll & Co.), Dec. 1, 1906.
 Styracol (Knoll & Co.), Dec. 1, 1906.
 Sublamine (Schering & G.), Dec. 8, 1906.
 Sulphonal (Cont. Color & Chem. Co.), Dec. 8, 1906.
 Suprarenal Alkaloid, Dec. 8, 1906.
 Suprarenal Liquid (P. D. & Co.).
 Suprenalin (Armour & Co.).
 Suprarenalin Ointment (Armour & Co.).
 Suprarenalin Solution (Armour & Co.).
 Suprarenalin Triturates (Armour & Co.).
 Tannalbin (Knoll & Co.), Dec. 15, 1906.
 Tannigen (Cont. Color & Chem. Co.), Dec. 8, 1906.
 Tannoform (Merck & Co.), Dec. 15, 1906.
 Tannopin (Cont. Color & Chem. Co.) Dec. 15, 1906.
 Theobromine, Dec. 15, 1906.
 Theobromine Sodium Salicylate, Dec. 15, 1906.
 Thieocin (Cont. Color & Chem. Co.), Dec. 22, 1906.
 Theophyllin, Dec. 22, 1906.
 Thermodin, (Merck & Co.), Dec. 22, 1906.
 Thiocol (Hoffman-LaRoche Chm. Works), Dec. 22, 1906.
 Thiosinamine (Schering & Co.).
 Thyreoidectin (P. D. & Co.).
 Tonic Hypophosphites (Sharp & Dohme).
 Tonols (Schering & G.), Dec. 22, 1906.
 Triferrin (Knoll & Co.).
 Triferrol (Knoll & Co.).
 Trikresol (Schering & G.).
 Trional (Cont. Color & Chem. Co.).
 Trioxymethylene (Merck & Co.).
 Triphenin (Merck & Co.).
 Triticum (Stearns & Co.).
 Tropococain Hydrochloride (Merck & Co.).
 Trypsogen (G. W. Carnrick & Co.).
 Tumenol-Ammonium (Koechl & Co.).
 Tumenol (Koechl & Co.).
 Tumenol Sulphone (Koechl & Co.).
 Tumenol Sulphonic Acid (Koechl & Co.).
 Tussol (Koechl & Co.).
 Urethane (Merck & Co.).
 Uriform (Schieffelin & Co.).
 Uritone (P. D. & Co.).
 Uropherin (Merck & G.).
 Urotropine (Schering & Co.).
 Urotropine-New (Schering & Co.).
 Validol (Bischoff & Co.).
 Validol Camphoratium (Bischoff & Co.).
 Valyl (Koechl & Co.).

Veronal (Merck & Co.).

Vioform (Bischoff & Co.).

Vibutero (Stearns & Co.).

Vioform Gauze (Bischoff & Co.).

Vinum Extracti Morrhuae, Stearns,
(Stearns & Co.).Xeroform (Heyden Chem. Works), Sept.
29, 1906, Oct. 13, 1906.

A POCKET CASE FREE.

Dr. E. R. Mason, of Charlotte, N. C., in an able paper in the JOURNAL of the South Carolina Medical Association, entitled "A Plea for a Simpler Materia Medica and More Rational Medication," makes the following strong, clear statement:

"I believe that the use of the active principles is one of the greatest advances in medicine in recent years because it is teaching men to think of the physiological action of drugs, to study the condition of the patient, and apply the drug that is indicated in doses sufficient to produce the desired effect, instead of using complex prescriptions whose physiological action they can only guess."

Doctor, if you want to know more about the advantages of the active principles send your name and address with ten cents, (to cover the cost of mailing), to the Abbott Alkaloidal company, Chicago, and they will send you free this six-vial pocket case filled with representative single active-principles along with other samples and their complete price list.

Make it twenty cents in stamps, and they will include a copy of Dr. Abbott's Alkaloidal Digest, a 300 page crystallization of the essentials of active-principle therapy with clinical applications. This is indeed a very generous offer. It is made to be accepted once only, to every physician who will mention this JOURNAL. We suggest that you write at once. Adv.

Pneumonia—On January 11, 1905, Mr. C——, aged 20, was stabbed in the back below the scapula, and when I saw him twenty minutes after the affray, he was suffering from profound shock. I carried out the usual operative proceedings, and the patient rallied, doing well until the night of the eighth day, when he had a severe chill, presaging pneumonia.

I feared a fatal result, as the left pleural cavity contained considerable bloody serum, and immediately applied a thick dressing of **Antiphlogistine** ten inches wide, from the spinal column to the median line, in the front, and kept up this treatment for three weeks, changing the dressing every morning. By this time the lung was perfectly clear, and there was no further use for the external application.

The **Antiphlogistine** was covered by a cotton jacket and held in place with a cloth bandage. The pain was relieved by hypodermics of mor-

phine and atropine, and the heart was sustained by strychnine. Outside of a little calomel and some laxatives, there was no other treatment. I aspirated the pleural cavity and drew off the serum. In view of the complications in this case, I consider it rather remarkable that the patient made so excellent a recovery. It only confirms my own high opinion of the remedial value of **Antiphlogistine**.—J. A. DAVIS, Norman, Ok. Adv.

For Sale—Practice and residence in good country town in north-east Kansas: or will sell practice and introduce purchaser. Address No. 42 care of the JOURNAL.

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MYCOSIS FUNGOIDES.*

REPORT OF A CASE.

R. E. McVEY, M. D.,

Prof. of Skin and Venereal Diseases, Kansas Medical College.

Topeka, Kansas.

A history of a case of Mycosis Fungoides, which was shown before the Medical Class
October 2, 1904, in the Kansas Medical College.

Mycosis fungoides fungi consist of cellular plant life with root, stem and leaves in one general mass. They receive their nourishment through spawn or mycelium, living in air and soil, propagated by spores, which are colonies sometimes enclosed in tubes. Fungi are closely related to moulds and algae but grow in different situations. They are found in green pastures, on decaying trees, cereal grasses, on animals and man, their presence in the skin produces irritation of an inflammatory character, the symptoms of which in the first stage, are much like those of eczema, or urticaria, accompanied by the same intense itching and burning. Mycosis fungoides is divided into two stages, primary and secondary. The second stage is the tumorous stage. The tumors are oval in shape and some of them quite large and ulcerated. The disease is malignant in the tumor stage and proves fatal in the majority of cases. The disease is classed as belonging to the infectious granulomata. McVail, Murray, and Atkinson, isolated a bacillus with rounded ends, sluggishly motile, which grew on agar in twenty-four hours in the form of creamy white round colonies.

*Read by title at the Topeka meeting of the Kansas Medical Society, May 7, 8, 9, 1906.

From these cultures, rabbits were inoculated, which produced death in from twelve to sixteen days. The bacillus was found in the enlarged lymphatic glands of the rabbits. These bacilli have not been found in subsequent cases that I know of. There are a number of varieties of fungi which are allied to each other in function that may act as irritants and set up inflammation and granular degeneration in the skin and other tissues of the body. The tumors are tomato-like in shape and spongy in character.



MYCOSIS FUNGOIDES (McVey).

Ina May was brought to me October 2, 1904 suffering from Mycosis Fungoides in the secondary or tumor stage of the disease. On the left eye and left cheek were large fungus tumors which had ulcerated. There were slight mucous or gummous secretions in the ulcerations. In the largest tumor over the eye, under microscopical examination, the ordinary pus germs were found. In this tumor there was quite a marked tendency to hemorrhage. Nothing was found in the microscopical examination that would explain the primary cause of the affection. The disease first appeared from report of the parents of the child, as an urticarial eruption which was attended with severe itching but no particular constitutional disturbance. Besides the tumor on the face, as shown in the picture, there were, on other portions of the body, circumscribed erythematous patches. These patches were from the size of a ten cent piece to that of a dollar, some of them were upon a level with the skin while others were from $\frac{1}{8}$ to $\frac{1}{4}$ of an inch above

the skin. Many of these little tumors had undergone absorption. The physician who had charge of the case before it came to me had blistered the erythematous patches on the face. These blisters had been repeated from time to time which was soon followed by the secondary or tumorous stage of these patches. Whether there was hereditary taint in this child or not I am not able to say, but the father of the child says that when he was a child and until the time of the development of manhood, he had such an eruption over his body with the formation of tumors like the child, only that they did not ulcerate, but after his development into manhood they all disappeared by absorption and since that time his health has been fairly good and there has been no return of the affection. He says that the disease in the child and in himself were similar but whether it was the same affection or not I am not able to say.

In this case as there seemed to be some indications for an alterative treatment, I gave the child syrup iodide of iron, 5 drops three times a day. Local treatment, Finsen light 15 minutes each day. Oleate of Bismuth in the ulcerated tumors. After about three months, diarrhoea set in which could not be controlled and was followed by death, which is the usual result of such cases, and which was probably the result of general streptococcus invasion. Before using the Finsen light the tumors were covered with adrenalin chloride, for the purpose of diminishing the blood in the parts before using the light.

The diagnosis of the malady in the first or primary stage is very difficult in as much as the cutaneous manifestations simulate a number of other diseases of the skin, as urticaria, erythema, psoriasis and eczema. Eczema is very closely imitated by mycosis fungoides and the appearance of some of the early lesions are identical with this disease, but the circumscribed nature of the patches of Mycosis Fungoides, their chronicity and their slight tendency to discharge, will generally serve to procure a proper differentiation. There is strong resemblance between mycosis fungoides and multiple sarcomata of the skin, both in microscopical and macroscopical appearances. But sarcoma is not preceded by an eczematoid and lichenoid eruption and the tumors are never absorbed.

Mycosis fungoides is a chronic disease with an average duration of from three to eight years. Patients may improve from time to time either from results of treatment or the nature of the disease, but it usually terminates fatally.

While the result from the use of the light were not what I had hoped they would be, yet I do not feel like saying that in similar cases the light would be of no avail, as the disease was so far advanced as to be hopeless before the light and the adrenalin was used. Should I have another case I should resort to the same treatment.

APPENDICITIS.*

L. MURDOCK, M. D.,
Sabetha, Kansas.

For years the etiology of inflammatory conditions of the bowels, fatal in termination, was unrecognized. Lesions of the appendix were looked upon as the sequelae of intestinal diseases. It was not until the latter part of the last century that it was recognized that the appendix was susceptible of disease within itself; and the present surgical treatment of the vermiform appendix is only a development of the last quarter of a century. With the introduction of antiseptic surgery came the treatment of appendicitis by celiotomy. The frequent opening of the belly has demonstrated that inflammatory conditions affecting the lower right abdomen are consecutive to diseased conditions of the appendix and not as formerly taught the result of perityphlitis. Progress has marked each step in the investigation of this disease and finally placed it where it properly belongs, as a strictly surgical one.

The anatomy, pathology, symptoms and diagnosis of this disease are fresh and bright in the minds of every practitioner and surgeon. The profession is almost unanimously agreed upon the surgical treatment of appendicitis; yet there are a few faltering brethren who advise against surgical procedure in appendicitis and claim to cure this disease without the use of the dreaded knife. They agree with the osteopath, the magnetic healer, Carson of Kansas City, and the Christian Scientist that this disease is amenable to other than surgical treatment.

The osteopath in Kansas is allowed to practice his so called profession, call upon the sick and suffering, feign to diagnose the case, administer olive oil, give an injection, apply hot or cold applications and collect his fees under the laws of Kansas, by simply registering a diploma; while a graduate of the best medical college in the United States is required not only to register his diploma, but pass an examination. It seems to me but justice that the osteopath should be required to pass the same sort of examination.

The Carson "Temple of Health" in Kansas City is sending broadcast over the country literature upon the subject of appendicitis, appealing to public mind to cure appendicitis without the use of the surgeon's knife, receiving money daily from poor duped sick and suffering people upon promises that cannot be made good. I had a patient treating with this fraud in Kansas City, who has had a number of attacks of catarrhal

*From the Northeast District Society.

appendicitis. This patient claims to have been cured when he simply recovered from the attack. That portion of our profession which stands against interval operations and maintain its ability to cure this disease by drugs is simply adding fuel to the fire kindled by these quacks.

Since Jan. 1st, this year, we have operated upon 85 cases of appendicitis in the Sabetha Hospital; out of this number I have chosen a few cases for this report.

CASE No. 1. —————, aged 19; single. Suddenly taken with pain in lower right abdomen; severe chills; night sweats; vomiting. This case was treated three weeks medicinally; each day the patient was advised that any operative procedure would be hazardous; that his condition would not permit of surgical interference and was assured by the physician in charge that he had cured many cases of appendicitis and had never found it necessary to operate upon them. After three weeks of this treatment the patient, becoming more septic each day, I was called. Upon examination I found his temperature 102, pulse 100; resp. 28; a large fluctuating tumor in the right iliac which was unmistakable. This patient was removed at once to the hospital; the tumor incised and a large quantity of pus evacuated; there was no attempt at removal of appendix; the cavity packed with sterile gauze. His recovery was rapid and uneventful.

CASE No. 2. —————, German, aged 21, single. Admitted to the hospital after three days of suffering with pain in the abdomen. Temperature 101; pulse 120; resp. 20. The lower part of the abdomen was swollen and all the abdominal muscles very rigid. No tumor; immediate operation decided upon. On opening the abdomen found fecal matter in the peritoneal cavity; also a green exudate of lymph upon the bowels. After cleaning this away the appendix was found dead and removed; the lower end of the colon closed. The wound dressed open, being packed with sterile gauze. To the surprise of all this patient made an uninterrupted recovery.

CASE No. 3. Dr. C ——— F ———; age 30; married. Entered the hospital at 3 p. m., Tuesday with a temperature of 99 4-5; pulse 80; resp. 26. Two days before he had suffered severe pain in lower abdomen, which continued all through the night; the next day the doctor was up; felt uneasiness in region of appendix and returned to his bed; on examination very sensitive and tender in the region of McBurney's point; no tumor. The doctor having been with me in the preceding cases would take no chance and the morning of the third day of his attack I operated upon him; found the appendix in a mass of adhesion, sharply curved; gangrenous and filled with pus. It was with great difficulty that this appendix was removed; there was also on the head of the colon a green exudate of lymph. The doctor's recovery was rapid and uneventful.

CASE No. 4. A ——— S ——— B ———; age 26; married; farmer. Ten years previous had suffered from an attack of peritonitis which confined him to the bed for about two weeks. Has enjoyed good health from that time to the present. Was taken with severe pain in the right groin; chill; nauseated and sweating profusely. Dr. Ham of Beattie recognized the man's condition and advised immediate operation for appendicitis. This man was brought to the hospital; when admitted had a temperature of 99½; pulse 130; resp. 28. Rigidity of all abdominal muscles with a general peritonitis. This case was operated upon; the appendix was found dead and gangrenous; a fecal concretion was also found in the cavity, which had sloughed through the wall of the appendix about midway between the tip and base. The gangrenous condition in this appendix was rapidly extending to the viscera and a green exudation of lymph was present upon

the head of the colon. This case was dressed open the cavity being packed with sterile gauze. The recovery in this case was slow and tedious; the gangrenous condition extended into the abdominal muscles which delayed the man's recovery for about ten days. This condition was finally controlled by moping the tissues with bromine; immediately following this the gangrenous condition disappeared, and his recovery was without further difficulty. This patient was in the hospital seven weeks.

CASE NO. 5. B—————, Summerfield, Kansas, age 22; farmer. While returning home from town was seized with severe pain in the lower right abdomen. The pain continued; he became nauseated and had a slight chill; Dr. Dodds of Summerfield was called; the doctor recognized the man's condition and without delay brought the man to the hospital for operation. When admitted his temperature was 100; pulse 112; resp. 22; tenderness and pain over McBurney's point, but no tumor or swelling. The following morning (36 hours after first pain felt in abdomen) the patient was operated upon. The appendix was found imbedded in the serous coat of the caput coli, about 3½ inches in length. This appendix was nested not only in the wall of the bowel, but was covered with bands of adhesion. When this appendix became inflamed and swollen the adhesion strangulated the circulation and death of the appendix resulted. With considerable difficulty the appendix was removed; the serous coat of the bowel was closed with catgut sutures. The patient's recovery was uninterrupted; returned home well in just two weeks from the time operated upon.

The important fact I desire to call your attention to in these cases is the temperature, increased pulse rate and almost the total lack of grave symptoms to justify the radical procedure of laparotomy; yet in each case reported, death would have ensued if radical and positive treatment had not been followed,

The Bloodless Phlebotomist. The Denver Chemical Co., is continuing the publication of this interesting little monthly. The February issue contains an article on sodium glycocholate mass in diseases of the liver, which it is worth while to read. We believe that the publishers send copies of the journal on request, so our readers can secure this article easily by sending a post card to 57 Laight street, New York City.

FOR SALE—Ideal location in northern Kansas. No competition. Will sell for price of residence. Cheap. Full particulars upon request. Address No. 43 care Journal, Rosedale, Kansas.

ELECTRO THERAPEUTICS.***I. HISTORY.**

U. G. ILES, M. D.,

Seneca, Kansas.

To wield the thunder-bolt was the marked attribute of the chief gods of old—the lightning flash was the surest proof of the presence of the divinity. Indra, the Jupiter of the Hindoos, was the god of thunder: the Etruscan Tinia always guided the electric storm: Jupiter Tonans waved his thunder-bolt over trembling Rome: and in every form of ancient superstition a belief in the divine origin of the most startling of heavenly appearances lay at the base of the national faith. When it thundered the grave Romans dissolved their political meetings and the wise Greeks listened with unfeigned awe. The gods spoke from the heavens in the rattling of the passing storm, or wrote their rage upon the earth in the ruin of the lightning stroke. And now like Indra, or Jupiter, the genius of modern civilization bears in its right arm the thunder-bolt as its crowning attribute. It has snatched the lightning from the skies and made it the most docile of servants. The electric flash is busy day and night in doing the work marked out for it by our modern magicians. It flies swifter than Ariel to carry its master's message, and puts a girdle round the earth. It dives in mid-ocean, rides over deserts and forest, It prints our books, prepares our paper, dissolves our gems and consumes platinum. An electric light turns night into day, electric processes aid almost every kind of mechanical labor, and the thunder-bolt of Jupiter is everywhere toiling in the cause of human progress.

Of all the achievements of modern civilization, this is the most remarkable. Steam is gross and material: there is little that is poetic or great in the rattle of the train or the roar of the monstrous engine. We can easily account for the mightiest of machines impelled by boiling

*In preparing this paper for the Northeast Society, I contemplate giving a series of papers on electro-therapeutics, beginning with the history of electricity and its development as a therapeutic agent, followed by a paper on the various apparatuses, their care and general technic, then taking up in following papers the different ailments successfully treated by electricity.

In presenting the history, I must of necessity obtain my knowledge from others who have worked in ages past and left a record of their labors. So this paper is produced mostly by quoting from what others say, and condensing it to the time admissible to be read before a meeting like this, selecting the wheat from the chaff and placing it into form to give a complete record. In so doing I have consulted the works of J. M. Bleyer, G. Betton Massey, Beard & Rockwell, and others.

water. Gunpowder and nitro-glycerin, oxygen and hydrogen seem the natural servants of inventive man. But when we attempt to catch the idea of the electric spark, it still appears almost as superhuman and terrible as when it flashed fear into the hearts of Greeks and Romans. It obeys with scrupulous accuracy: it performs the smallest, as well as the most important tasks, with equal care: it is docile as was the genii to Solomon's seal: and yet it still remains shadowy, mysterious, and impalpable. It still lives in the skies, and seems to connect the material and spiritual. Whence came these tongues of fire: these sharp shocks: these pale ghostly lights that play around us and mock the master they obey? Who is it that wields this electric element which seems to be the very base and source of our existence?

The ancient Pheonician voyagers brought back from Prussia and the shore of the Baltic a substance prized for its color and transparency. It was amber, or electron. The natives found it floating upon the waves or dug it up from the mines which still form a source of the wealth of Prussia. Thales, a Greek sage, over twenty-five centuries ago discovered that electron, when rubbed, had the property of attracting to itself various light articles. His discovery was the first step in the great science of electricity.

The discovery was never forgotten. Other scientists later described the phenomenon. But the germ of the great science lay hidden in mystery. No one thought of connecting the action of amber when rubbed with the lightning flash. Nothing further was done in the study of electricity worth recording till the opening of the seventeenth century. An Englishman by the name of Gilbert began the study of the properties of electron. His discoveries, while meager, made his name famous. He enumerated various substances capable of producing electrical action. He noted the effect of the weather on electron and the magnet, and from his labors sprang up a science known as electricity. Gilbert's work, "De Magnete," was published in 1600, and soon the new science began to terrify and astonish men. Men were inclined, like Thales, to invest electrical substances with a soul.

While an Englishman discovered electricity, a Prussian in the land of amber was the first to invent an electrical machine, Otto Guericke of Magdenburg. It consisted of a globe of sulphur revolved on an axle while a cloth was held against it. Electricity was given out in sharp sparks sometimes attracting, sometimes repelling objects.

In the eighteenth century, Hawkesbee, also an Englishman, invented the glass electrical machine, and in 1830, Steven Grey began a course of experiments which unfolded the leading principles of the science. DuFoié of France soon after transmitted an electric spark through a cord thirteen

hundred feet long. Immediately followed the invention of the Leyden jar by a pupil of Prof. Musschenbrock, Cuneus by name, in 1746, in the town of Leyden, from which the jar takes its name. It is also sometimes called Kleist's jar, from Kleist, a clergyman in Pomerania, as it is claimed that he discovered it independently of Cuneus and a year before. The Leyden jar was soon employed in all the laboratories of Europe. It first consisted of a glass jar partly filled with water. It was afterwards improved by coating its sides with metal.

To Benjamin Franklin, electricity owed the most wonderful of all its achievements in the eighteenth century. He explained the action of the Leyden jar, and explained how iron points attracted electricity, declaring that thunder and lightning were produced by the same agent contained in the mysterious Leyden jar. He suggested that iron points be placed on high points and thus test the accuracy of his theory. His suggestions were received with laughter and shouts of derision by the Royal Society of London. They refused to print his papers in their proceedings. They looked upon him and his theories as the silly dreams of an ignorant provincial. But his theories found many supporters in Europe, and a large school of scientists assumed the name of Franklinists. In June 1752, he drew the lightning from the sky by means of a kite, a silk cord, and an iron key, thus proving his claims.

Franklin was covered with honors. Kings became his disciples. Europe was covered with iron points from Paris to St. Petersburg. The Royal Society of London made haste to repair its former neglect, and elected him a member and awarded him its highest prize.

It was soon observed that the human body was strongly influenced by the electric discharge: the blood ran quicker, the limbs were stirred, the spirits excited, the intellect aroused. Physicians recorded wonderful cures performed by the aid of electricity. Had not a panacea been discovered? Electricity was applied to various diseases and was found successful. It was heralded as a cure for all the pains that flesh is heir to. But the pleasing medical dream soon passed. It was found that even electricity of the Leyden jar could not repair the ill effects of disease in men brought on by their own excesses and dissipation. The pendulum swung to the other extreme and electricity as a medical agent was neglected. It has passed through many vicissitudes. Being recognized and employed by physicians and hospitals at times and then again thrown aside and left in the hands of the quacks. With each new discovery interest would be again awakened for a time. Failures and disappointment have brought this valuable agent into disrepute time without number, by the failure of the operator using it to understand or know what it would or would not do, and thus the tide ebbed and flowed for over two hundred years.

..

The next great step in electrical progress was in 1790-1800, by the studies and researches of Galvani and Volta, resulting in the invention of the Voltaic pile or Galvanic battery. It was composed of alternate layers of zinc and copper. From the action of the muscles of the body by the electric current, even when the head had been severed, Galvani imagined that he was on the point of discovering the origin of life.

With the discovery of induction by Prof. Faraday of England in 1831, electro-therapeutics began to make substantial gain.

During the first three-fourths of the nineteenth century, less was done in America than in Europe to advance electro-therapeutics.

To the tireless energy of such men as Duchenne of Boulogne, Matteucci du Bois-Reymond of Berlin, and Tripier of France, we owe much of our knowledge during the first half of the nineteenth century. Also to Prof. Remak of Berlin, M. Benedikt of Vienna, Julius Althaus of London, and Prof. Erb of Leipzig (now of Heidelberg) we are greatly indebted.

The last quarter of the century saw the greatest advance toward putting electro-therapeutics on a firm and scientific basis, by the introduction of the dynamo and the various instruments for measuring the dosage, estimating the resistance and electro-motive force. Of the master hands that moulded European electro-therapeutics, we have Gaertner of Vienna, Apostoli and d'Arsoval of Paris,—the work of the latter two in particular.

In America we find Prof. Mussey of Ohio as early as 1823 treating cancer and other tumors by electro puncture. Also Doctor Thomas Brown of Albany treating paralysis, tic-douloureux, epilepsy, chorea, and various diseases by the Franklinic electricity. But no form of electricity was used systematically by anyone except quacks or, possibly, physicians too modest to record their results, until the late George M. Beard and A. D. Rockwell of New York made a scientific investigation of the subject. They issued their first work on the subject in 1871. Their efforts to rescue American electro-therapeutics from quackery was ably seconded by S. Weir Mitchell and the late William A. Hammond.

Prior to the time known as the age of the dynamo, progress was slow and consisted mainly in the use of the convenient faradic battery. This limitation and the failure to employ Erb's rules for the dispersion of stronger currents resulted in the arrest of the progress of American electro-therapeutics until the impetus it received by Apostoli's work with heavy currents and scientific apparatus.

The American Electro-therapeutic Association was formed at the suggestion of G. A. Betton Massey of Philadelphia, since which time electro therapeutics has been coming to the front with rapid strides.

Among the modern workers in this field are Dr. Allen of Philadelphia

who introduced the electrical treatment of extra- uterine pregnancy, Dr. Morton of New York, who re-introduced static electricity, Dr. Newman, also of New York, the galvanic treatment of urethral stricture, G. Betton Massey, the electrical treatment of diseases of women, and Mercuric cataphoresis of cancer.

Electricity today,bridled as it is in the hands of the modern scientist and physician, is bringing forth ripened fruit, many ailments are now amenable to the current where other medical agents have failed, and America will shortly achieve the prominence in the medical application of electricity now enjoyed by her as the leader in the development of electrical arts and industries.

AMBULATORY TREATMENT OF FRACTURES OF THE LOWER LIMB.*

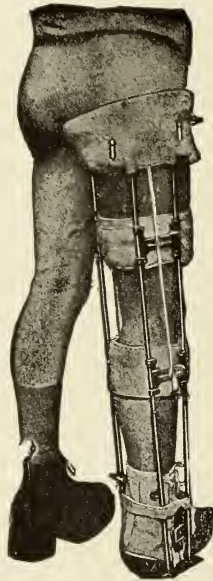
L. W. SHANNON, M. D.,
Hiawatha, Kansas.

The responsibility incurred by a physician upon being called to a case of fracture consists mainly first in saving the life of the patient, second in obtaining as perfect and serviceable a limb as possible, and third in saving the patient loss of time and its consequent expense. The time honored principle for treating fractures still obtains, viz accurate reduction and perfect immobilization, but the means to that end have been varied.

This paper is limited to a consideration of the fracture of the lower limb. I shall consider them under fractures above and below the knee, or fractures of the thigh and leg. The argument might be advanced that no better results can be obtained than by proper extension and perfect quiet in the recumbent position. No attempt will be made to prove the contrary. For such a procedure might be considered the ideal one if the fracture alone was all that needed consideration. But in many cases in fracture of the femur the patient is very aged and the contingencies that arise in such cases are frequently more serious than the fracture itself. The process of repair is usually slow and the dangers from a protracted recumbent position in such subjects have been so often experienced that they need not be repeated; and more too in many cases for the recumbent position becomes so irksome and painful to the hips and back that the very purpose of securing rest is defeated. Such conditions have necessitated in many instances, and the eagerness of

*From the Northeast District Society.

physicians in others have supplied, a modification of the method in hand and has introduced the ambulatory treatment. The methods used have varied in the hands of different surgeons. Probably the one most used until recently has been some form of a plaster cast.



AMBULATORY TREATMENT OF FRACTURES OF THE LOWER LIMB.

When a cast is used Kofmann recommends the cast used by Lorenz in coxitis. It extends below the knee and has included in its side irons which extend below the foot and then are attached to a cross piece. A sandal or thick sled shoe is worn upon the opposite foot. Kofman reports his patients as beginning to walk by the second or third day; when they are dismissed from the hospital to return after six weeks, when he has found all his cases with a perfect union and no deformity. This method in a modified way I saw used extensively during my internship and with comparatively good results. There was one case however which came under our observation after it had been treated after this manner which presented an angular deformity at the point of fracture which required an operation to correct. The trouble of it evidently had been a lack of proper extension—a difficulty which I think is hard to overcome when one depends upon a cast, for there is no way of knowing whether a proper extension is being maintained without opening the cast and then no way of adjusting it except by a new cast.

In the past few years many forms of splints for the leg and thigh have been devised and experimented with and in some of these it would seem a fair degree of perfect union had been attained. The points attempted to be maintained, viz., immobilization of the joint below and sometimes that above the seat of injury, retaining perfect reduction by continuous counter extension and immobilization of the seat of fracture. I have used and am using at present the ambulatory-pneumatic splint

which meets more of the requirements and at a better advantage than the cast. All the parts are adjustable and can readily be changed to meet indications. It is easily applied and when applied the seat of injury and other parts can be easily inspected without reducing the tension. This makes it very commendable in compound fractures where asepsis is exacted. The tension is maintained by adhesive straps to the side of the limb and are fastened to a plate beneath the foot and the tension is adjusted by a screw device which shortens or lengthens the sidebar braces; the counter pressure is against the tuberosity of the ischium and adjacent parts. A thick soled sandal is worn upon the sound foot which elevates the body and gives the limb a clean swing.

The splint might be applied at the first dressing of the injury but it has rather been a custom with me to first use what is known as a railroad splint, which is a modification of Buck's extension for the first few days until the acute soreness, tenderness and swelling have subsided and then to apply the splint, and after a few days encourage the patient to sit up and then to walk with crutches. Thus in any case the period of being confined to bed is reduced to from three to ten days, and convalescence is made much more agreeable to the patients and in some instances patients are enabled to go about their daily duties. My experience and observation however are that results in this respect—viz: the ability of the patient to ambulate—varies with the physical condition and ability of the person. A young, healthy, strong, athletic person will naturally handle himself to a better advantage than an aged person. However the method of treatment may be of far greater value to the latter in saving life than to the former.

The same splint may be used to good advantage for fractures of leg and foot, but in such cases I have never applied it because it seemed to me that a well applied plaster paris splint (not a cast) was just as serviceable and more economical. A perfect fitting splint is readily and easily made in a few minutes with only a few rolls of plaster of paris bandages. The moistened bandages being applied lengthwise to the limb in sufficient layers to make a firm yet very light but serviceable splint. This splint is then held to its place, or rather the limb is held in its position against the splint, by ordinary bandages. While it is true that a new splint must be made for each and every limb there is the advantage of its perfectly fitting. In case of compound fractures the wound is easy of access. In these cases also it may be necessary to apply a temporary dressing for a few days at least until the swelling has subsided. This temporary dressing might be a fracture box, well padded splints, or I have used a plaster of paris splint, if I think the limb is swollen as much as it probably will be and then apply new splints as the swelling subsides. Dressings of this

kind do not necessarily keep a patient in bed though for a few days comparative quiet is best. I have now a case of Pott's fracture of five weeks standing to which I applied such a splint within one hour after he sustained the injury.

He was out upon crutches the next day looking after his business, and has done so every day since. He has a perfect reduction and a good union.

The advantages to the patient of a method of treatment which will relieve him of the inconvenience of remaining in bed from six to twelve weeks needs but little argument to commend it to a more general use, especially when results are equally as good if not better. And the advantage of a splint over a cast in the way of extension, immobilization, readiness of access and inspection and the convenience and comfort to the patient is giving it a prestige.

MAJOR COMPLICATIONS AND TREATMENT OF PNEUMONIA.*

E. N. MARTIN,
Benedict, Kan.

I am prompted to discuss this division of the general subject of pneumonia, first, because it is practically impossible to cover the subject as a whole in one paper; secondly, on account of the very unusual number of serious and even fatal complications; lastly because of the wide diversity of opinions as to treatment, all of which perhaps proving equally successful in the hands of their authors.

Pneumonia is a much discussed disease, especially the treatment and while the study and discussion of the subject has been more or less fruitful it has not altered materially existing conditions. The prevalence and fatality of pneumonia the world over is astonishing, it being the only one of the infectious diseases that has not in a measure yielded to the efforts of the profession. In fact it has increased or has kept abreast of the increasing population. The death rate in cities and hospitals has materially increased: just why I am unable to explain unless it be as one author has said that improved sanitary conditions have spared the lives of the feeble, aged, and weakly infants only to have them claimed by this disease.

Dr. Osler says, "It is extremely hard to understand how physicians can sit mute and passive while listening to details of this sad

*Read by title at the Topeka meeting of the Kansas Medical Society, May 7, 8, 9, 1906.

state of affairs," "Mute and passive" is an expression well applied to our previous attitude towards pneumonia. But I am glad that there is an awakening among physicians, and we are becoming ardent for results. I am glad also that we are thrusting aside many of the visionary dreams that have haunted us in past years and have ceased to look upon any process with favor that does not bear rigid investigation. We have passed the point of taking things for granted and have to be shown.

Tyson says, "The seriousness of an attack of pneumonia varies more or less with the amount of tissue involved." This is true; but I am impelled to add that it varies much with the number and nature of the complications.

Regarding complications Stengel says, "Practically every case of pneumonia has more or less serious effusion either between the parietal pleurae or between the lobes." Since pleurisy is present in practically every case of croupous pneumonia its etiology, pathology and treatment must be matters of great import.

Pleurisy is rarely a primary disease and occurs most frequently as a sequel of croupous pneumonia. Butler says, "Inflammation of the pleura is doubtless for the most part a symptom of a condition rather than a separate disease." Hare says, "Indeed it may be said that in every case of croupous pneumonia a certain amount of inflammation of the pleura exists." Tyson says, "It probably is always present to a certain extent except in the central form." The etiology of pleurisy complicating pneumonia is therefore simple and need not be discussed except to say that there may possibly be a tubercular factor in some cases. It is a fact conceded by all authors that in this class of cases the pneumococcic infection or some organism associated with it in the lung and by extension to the visceral layers of the pleura is the initial cause whatever may be the character of the pleurisy—whether it be dry or an effusive, tubercular or otherwise. Diverse conditions exist in the pathology of pleurisy complicating pneumonia. It may be a dry pleurisy and in many cases is, as I have found in my practice. There is no exudate in these cases and consequently much pain and distress from contact of the pleurae. The pain and distress in these cases are diagnostic points of great value.

Pleurisy with a serous effusion, another possible and common complication of pneumonia, adds much to the gravity of the situation. The many possibilities of the development of enormous accumulations, limiting mechanically cardiac and lung activity gives this complication also a grave aspect. The serofibrinous exudate often accumulates very rapidly, and often disappears more rapidly, it being a well known fact that the absorbent power of the pleura is often greater than the

effusive. This complication may occur at any time during the course of the disease.

Quinine in moderately large doses, especially at the onset of this form of pleurisy is excellent treatment. It will do for this with reference to the local process, much the same as it does for pneumonia proper.

Iodide of potassium four to eight grains every five to six hours, calcium iodide, iodide of arsenic, and the syrup of the iodide of iron have done good service in my hands. These remedies and others if indicated, should be continued even after paracentesis. Surgical treatment should be used whenever there is sufficient accumulation to limit materially the normal activity of the various organs that are affected by the pressure. Counter irritation even to the point of large blisters is good treatment in these cases, often arresting the process and hastening the reabsorption. The technique of aspiration need not be described here except to call your attention to the very urgent need of aseptic precautions. Carelessness in this would be unpardonable. During the last winter four out of ten cases of pneumonia among the children in my practice had a sero-fibrinous effusion in sufficient quality to manifest its presence. In all of these cases the effusion was readily absorbed and disposed of without surgical interference.

I am convinced that many cases of sero-fibrinous pleurisy complicating pneumonia exist in children that are never discovered. We do not examine for these conditions carefully enough. Usually they are insidious in their onset, we are not aware of their presence until they are fully developed. I have lately made it my practice during every visit to examine very carefully for just such conditions and the result is almost startling. In the ten cases mentioned above 40% had effusions. This rate will not hold good, however, in a series of cases including adults. Carmichael says "It is especially prevalent in childhood and particularly in large proportions in infants under two years of age."

Empyema is perhaps the most serious of all complications which we have to contend with. Some empyemas are easily relieved; others are most intractable, and show a strong disposition to be obstinate, and a tendency to recur. The quantity of pus may be large or small, usually large, sometimes enormous as you will see in a case I shall report later. It may be unilateral, bilateral, ensacculated, circumscribed, or diffuse. May be sterile, (rarely if ever in my judgment) or may abound with, *staphylococci*, *staphylococci*, *pneumococci*, *tubercular bacilli*, etc.; anyone two or more or all combined. May be odorless, as is usual in pneumococcic infection alone, or may be fetid especially when there is an opening into air cells. May be thin in consistency, as in early cases, or may be thick and curdy, as in cases of long standing. May be

ushered in with a chill or may not be. The large variety of conditions that may prevail in these cases renders an absolute diagnosis practically impossible and only by the use of the aspirating needle are we able to arrive at a positive conclusion. Marked cyanosis, and even more marked dyspnoea; rapid pulse and irregular, pain in various localities, frequently in the shoulder on the afflicted side, cause anxious expression and a sudden rise of temperature, are all significant indications, and if we have not already suspected an empyema, it will be well to examine for it.

CASE REPORT.

A man 33 years of age weighing 165 lbs., with a good family history, passed through the usual stages of pneumonia. And after waiting some time for convalescence, symptoms of an effusion developed. The thorax was tapped removing about $\frac{1}{2}$ pt. of serum. The patient then left the high altitude of Colorado and came to south-east Kansas. On November 17th, I saw the patient in consultation and the same day we removed ten pts. of pus from the rt. thorax. On the 19th, the patient suffered a very severe collapse and it was only by the most heroic efforts of the physician and the family that he was induced to continue his sojourn with us.

I saw the patient a few hours after this last incident and was convinced that the end was near. I left a few hours later expecting momentarily to hear of his death; but he survived and on the 28th, eleven days after the first operation, the effusion was again enormous. This time we removed eleven pts. of pus and following flushed the cavity with a hot boric acid sol.

On December 12th, I saw the patient again and he was apparently doing well with no indications of a return of the trouble. The air was entering the lung in a surprisingly free manner. All the symptoms had abated only to be renewed later.

On January 2nd, a third and last operation was done for the patient's relief. A spacious opening was made in the axillary region between the sixth and seventh ribs, and after draining off an enormous quantity of pus, more than at any previous operation the cavity was thoroughly flushed and two drainage tubes were sutured in the wound. After this operation the patient made a slow recovery.

This case illustrates how enormous these effusions may become, and also that each succeeding accumulation has a tendency to become larger than the previous one. The treatment of empyema is surgical and supportive as indicated in the case just reported. They may become incysted if small; but I am sure that it is always much better to relieve them to have them remain even in a encysted state.

Regarding the surgical treatment, I am not impressed with the theory that in all such cases a rib, or perhaps several ribs, need be resected. And I believe that only where there is not sufficient intercostal space to obtain free drainage need ribs be resected. The treatment of pleurisy in general outside of surgical may be divided for convenience into two classes. First supportive, carbonate of ammonia, strychnia and nitro glycerin, alteratives, and stomachics; secondly, counter irritation, blisters leeches, bleeding, cupping, etc.

Fifty years has marked a complete change in the treatment of pneumonia. Doctor Gillian says in an article on the treatment of pneumonia published in the Kansas City Medical Record, not to expect anything scientific from his paper. That has been one of our major faults. We have not been expecting enough and consequently we have gotten what we expected, namely nothing. I do not intend this as a criticism of Dr. Gillian's paper for I enjoyed it and obtained much valuable information from it. But I did mean to call attention to that one point as an illustration of our former attitude towards pneumonia.

I will not attempt to analyze carefully our methods of treatment for, as I have said, it is largely symptomatic and palliative, but if possible make a few suggestions that I hope may be used to indicate a proper future course. Do not think that I am condemning symptomatic treatment; I am not, for it is the best we can do. But let us not think that if a certain drug or combination of drugs or other applications will reduce temperature that this drug, etc., is a specific for pneumonia.

The ice pack and cold applications; aconite and the coal tars have doubtless done valuable service but quinine is a febrifuge. It prevents excessive oxidation and has a selective action the thermo-toxic mechanism, consequently it reduces the temperature. Bleeding is the most picturesque of all ancient methods, was efficient then and is now in a measure. Cupping, leeching, large blisters, and hydragogue cathartics, all deplete and relieve blood pressure. Quinine in large doses will relieve arterial tension and slow the pulse by a direct effect on the cardiac ganglia, doing the same as the above without producing any evil effects. Quinine is antiseptic in its effect on the blood. It increases the leucocytes or the combative properties. Quinine produces cerebral anaemia lessening the effect of the toxins on the general nervous centers by lessening the blood flow.

Iron increases the red blood cells and builds up an impoverished blood. It renews the red cells that have been lost or destroyed by excessive oxidation or other agents. It acts as a general tonic and builder of the blood. Now what have we done for the local process in the lung? First we have dilated the arteries and capillaries giving a freer circulation through the lungs and lessening the sifting qualities of the capillaries thus in a measure preventing the accumulation of much debris. Second, we have reduced the debris in the blood and lymphatics to a minimum. Third, by a combination of the above we have prevented in a measure the infiltration of the lung and aborted the attack. Give the patient a sparing but highly nutritious and easily digested diet consisting of milk, cream, eggs, etc., also prepared foods if necessary. Give him plenty of water to assist in elimination, plenty of sunlight if obtainable; good ventilation, cheerful surroundings.

Society News.

Report of the meeting of the Council of the Kansas Medical Society.

The council of the Kansas Medical Society met in Dr. Munn's office in Topeka on the evening of February 5. All the members of the council were present except Doctors Furst and McCarty. The first district (Dr. Goddard) reported all the counties of that district organized save Jefferson, but that some of the counties were not in very good standing. The second district (Dr. Jarrett) reported all counties organized except Woodson; and, that the interest in this district was gradually increasing. The third (Dr. Daily) reported an excellent condition of affairs. Not only were all the counties organized, but all were working toward the unity of the profession; and, included homeopaths, eclectics, and all registered physicians. The fifth district's report (Dr. Alkire) showed that both Morris and Marshall counties were unorganized. The doctor was unable to find any body in those counties willing to take the trouble to answer his correspondence. The seventh district (Dr. Sawtell) showed that organization existed in every county, but that Franklin county would not affiliate because of a misunderstanding regarding the status of homeopaths. The eighth district (Dr. Cludas) is progressing slowly. The Western Kansas Medical Society has formed a fine organization and is taking care of the western end of the district. Nevertheless, Ellsworth, and Trego, and Hays counties are showing a great indifference to the matter of organization, in spite of the fact that in these counties are located some men that have previously been prominent in society affairs.

Dr. Hoxie, editor of the Journal, presented his resignation; and Dr. Huffman was elected to take that position in connection with his work as secretary to begin with the May issue. His remuneration was fixed at \$1000.00 per annum.

It was decided not save any sections or symposia at the Kansas City meeting of the Kansas Medical Society. The time for discussion for each paper was to be strictly limited to twenty-five minutes; and, each speaker to five minutes. Each essayist will be requested to send in, in time for printing in the program (March 15) an abstract of his paper; or, a copy of his paper itself.

The legislative committee reported that it had not received any particular suggestions from members of the society for new legislation; and, therefore, was not pushing anything this year.

The State Board of Health was commended in its efforts to protect the public health of the state.

Allen County Medical Society. Met at the court house January 14, 1907. **CLINICAL CASES:** Dr. Mitchell presents cases of meningitis, of unknown origin. Dr. Mitchell ascribing it to influenza, Dr. Martin is of the opinion that the probable cause is the bacillus of typhoid, Dr. Manley (who is taking part in the proceedings by invitation of the society) agrees to the diagnosis of meningitis, expressing no opinion as to cause, Dr. Bolton presents case of poisoning by rhus toxicodendron, the erythema resembling that sometimes produced by quinine. Dr. Martin gave a description of an unusual double hernia with undescended testicle incarceration of the omentum, and gangrene following.

PAPERS: Doctor Manley's paper on pneumonia lays particular stress on the therapeutic indications for five remedies, viz. Veratrum Viride, Bryonia, Lobelia, Asclepias, Ipecac. In external applications favors anti-phlogistine and flaxseed poultice and especially lobelia and capsicum over the sternum, discussion followed. Dr. McDowell commends the plan of treatment particularly the lobelia-capsicum application. Dr. Mitchell is very skeptical in regard to the control and cure of pneumonia by the use of drugs, he admits the necessity of external applications for diplomatic reasons even permitting the use of the fragrant onion poultice; suggests the trial of quinine on the evidence presented in current medical journals. Dr. Heylman calls attention to the action of strychnine and digitalis with supportive measures. Dr. Martin emphasizes the necessity of proper elimination and agrees with Dr. Mitchell that the disease is practically never aborted or cut short by the administration of drugs. Dr. Bolton strenuously advocates the alkaloidal idea for lessening the dose, more certain action and increase in specific effect that follows the employment of the single alkaloid. Mentions aconitine, lays particular stress on the virtues of strychnine sulfate, violently opposes the let alone policy, believes the disease can be aborted and cut short, reaffirms his allegiance to drugs in general and strychnine in particular. Dr. Manley closes discussion after a few remarks from the President (Dr. Rennick), reaffirms his confidence in plan of treatment and does not consider that veratrum is a heart depressant in the dose employed.

The following history of the society was ordered printed in the Iola papers:

The Allen County Medical Society as it is today is the successor of an earlier organization which existed at a time when a scant half dozen medical men were sufficient for the needs of the then sleepy village which had not as yet felt the vivifying effects of natural gas. With the growth of the town came an influx of physicians who having no acquaintance with each other, made successful organization peculiarly difficult. In the spring of 1904 this society formally disbanded and reorganized under the plan of the American Medical Association. The American Medical Association is a national

organization of physicians founded over fifty years ago. It consists of state societies who are in turn depended on by counties societies for membership and support. The national membership is approximately thirty-five thousand. The Allen County society includes practically all the physicians in the county who are eligible to membership—about thirty-five in number. Every legally registered physician practicing in Allen County who is of good moral and professional standing—who does not support or practice or claim to practice any exclusive system of medicine is eligible to membership. The objects of the society can be best stated by an extract from the constitution of the association, "The object of this association shall be to federate into one compact organization the medical profession of the United States, for the purpose of fostering growth and the diffusion of medical knowledge, of promoting friendly intercourse among American physicians, of safeguarding the material interests of the medical profession, of elevating the standard of medical education, of securing the enactment and enforcement of medical laws, of enlightening and directing public opinion in regard to the broad problems of state medicine, and of representing to the world the practical accomplishments of scientific medicine, with power to acquire and hold property, publish journals, etc."

It is one of the most liberal of all scientific societies. Each member having all the rights and privileges extended to another, expecting that tolerance of opinion of his own views that he extends to others. The physician's labor is peculiar in its isolation, without the association and contact of his fellow workers he is prone to succumb to a routine method, become morbid or pass his life in a self centered trance or develop the self conceit that is so presumptuous and intolerant of men's opinions.

Common sense teaches that man is a social animal whose progress is impossible without the co-operation of many minds directed to the solving of those scientific, economic and social questions which confront him. No science is so filled with problems of great moment as medicine. It is so progressive that a graduate of a year ago is behind in his work. To keep abreast of the times an active association is necessary. So pressing are the demands on the medical worker by the recent advances in the collateral sciences that constant interchange of ideas and results is necessary. The physicist discovers the X-Ray, the chemist a new element—radium, the biologist or embryologist contributes a new fact. Collective investigation is necessary for its successful application. The thousands spent in research are useless unless the results are applied by the practicing physician. An active local society is a guaranty to a community that it is receiving the benefits of all that is known to science in the cure and alleviation of disease. It is of no less value to the public than to the members themselves. This is shown in their attitude towards those things that concern the public health—such as vaccination, hygiene in the schools, control of the sale of poisons, pure food legislation, proper protection against epidemics, ventilation in tenements, child labor in factories and many other measures have become laws through their advocacy and influence.

It is of great importance that the laity fully comprehend the value and aims of an organization of this character.

They are particularly interested in preventive medicine. In animals other than man disease is unresisted and quickly eliminate the unfit. Man through his opposition to disease gives rise to new and terrible forms of it as shown in the survival of those who are physically unfit.

Disease will always be the heritage of the race and organized resistance will continue to be necessary. The great progress made in the control of infections is shown in the discovery of the carrying power of insects—such as the mosquito transmitting malarial and yellow fever. The absurdity of the shot gun quarantine in the light of

the proof of its ineffective character is apparent—a trifling flea which infests the rat is the carrier of the dreaded bubonic plague—flies and dust are also responsible for the transmission of disease. The danger from typhoid is very little when the water supply is free from the bacillus responsible for it. The great discovery of the age is that resistance is a function of the cell, that man possesses the inherent power to overcome infection through the action of substances which are elaborated for the purpose—in short, disease is preventable and the span of life can be prolonged—for example, anti-toxin in diphtheria has reduced the mortality to at least one-fifth the former rate. The average duration of life has been increased five years in the last quarter of a century by organized medical effort.

The temperance worker can receive encouragement in the crusade against narcotics from the demonstrated fact that the resistance to disease is lowered by their use, so violent a reaction has taken place in Great Britain over this discovery that legitimate medical uses of alcohol are endangered. When once the public is informed of the true object and aim of a county society intelligent opinion will demand that the physician keep abreast of the times by the educational advantages offered. The Allen County society has always been an active one and has succeeded in getting itself cordially hated by every fraud and quack in the country, together with those whose mercenary motives aligns them with them. A proud record. For the opposition of such is the highest compliment that can be paid to the usefulness and integrity of the society. The work is not finished, the unsolved problems that interest the national organization interest it as its auxiliary. The safe anaesthetic, the cause and cure of cancer, the stamping out of consumption, the proper recognition of mental alienation in its varied forms, life insurance—the cheaper insurance from improved risk—the compilation of vital statistics are only a few that may be mentioned. Good citizenship and all the things that add to the durable satisfaction of life.

In the future of Iola and Allen County we have our place. We are attempting to fill it so that our earnestness and sincerity for the welfare of the community will remain unquestioned.

G. C. GLYNN,
Secretary.

Cherokee County. Program for 1907.

JANUARY

Scarlatina, Dr. R. G. Wear
Fees and Insurance Examinations..... Dr. R. P. Scoles

FEBRUARY

Influenza..... Dr. W. N. Johnson
Surgical Conditions of the Liver..... Dr. H. H. Brookhart

MARCH

Rheumatism..... Dr. H. B. Savage
Dysmenorrhoea of Adolescence..... Dr. P. J. Hendrickson

APRIL

Summer Diarrhoeas..... Dr. G. W. Walker
Ethics..... Dr. J. H. Boswell

MAY

Pulmonary Tuberculosis..... Dr. W. N. Johnson
Surgical Tuberculosis..... Dr. R. M. Markham

JUNE

Malaria.....	Dr. J. P. Scoles
Continued Fevers.....	Dr. H. B. Savage

JULY

Typhoid.....	Dr. J. H. Buckles
Gonorrhoea	Dr. R. Claude Lowdermilk

AUGUST

Now Operative Treatment of Endometritis.....	Dr. A. A. Shelley
Diseases of the Rectum.....	Dr. H. H. Brookhart

SEPTEMBER

Spinal Scleroses.....	Dr. H. P. Mahan
Syphilis.....	Dr. L. W. Baxter

OCTOBER

Membranous Croup vs. Diphtheria.....	Dr. Geo. P. Bell
Fractures of the Upper Extremities.....	Dr. Chas. S. Huffman

NOVEMBER

Chronic Gastritis.....	Dr. Geo. B. McClellan
Gun Shot Wounds.....	Dr. H. A. Browne

DECEMBER

Urinalysis as a Guide in Diagnosis.....	Dr. J. P. Hendrickson
Minor Surgery.....	Dr. R. Claude Lowdermilk

Clay County Society. Meeting for February 13, 1907.

The Druggist and the Doctor, Dr. C. C. Stillman.....	Morganville
Puerperal Eclampsia, Dr. H. E. Potter.....	Clifton
Fractures and Their Treatment, Dr. John P. Kaster.....	Topeka
Paper, Dr. L. R. King.....	Junction City

Pennsylvania raises the requirements for admission to Medical school. Recognizing the advantages of a broader general education and the growing necessity of the prospective student having in addition special preparation for the study of medicine, the Board of Trustees of the University of Pennsylvania has decided recently to raise the requirements for admission to its medical school. These requirements include two years of general college training and in addition a certain knowledge of biology, chemistry and physics. According to the plan which has been adopted, the standard will be raised gradually, beginning with the academic year 1908-1909 and reaching the maximum 1910-1911

THE COUNTY SOCIETY.

J. A. CONNER,
Burlingame.

So many ably written articles have appeared lately in the medical press relative to the "County Society" that it seems the ground has been thoroughly covered, and that about all that is left to say on this subject will be but a resume of what has been said before by such thinkers and workers as McCormack of Kentucky, Jones of California, Chase of Texas, Hayes of our own state, Ward of Massachusetts, and many others whose articles have not escaped my notice. It would be strange indeed, if, having read and studied these masterful treatises, I should not reflect much that I had read and approved of; I will therefore confess to premeditated plagiarism, and can only offer as an excuse, the pressing need of having the fundamental truths of medical organization continually hammered into our membership until a united medical profession of the whole country will be enabled to protect the health of the public and the purse of the physician.

What is an ideal County Medical Society?—It is an organization composed of all the reputable physicians of its territory, which meets at certain intervals to transact business which may be summed up as follows:—

(a) **Self-preservation.**—The Society must live in order to be useful, hence the need of self-preservation,—here as elsewhere Nature's first law. There are certain dangers to be guarded against and these may be internal or external. Among the

(1) **Internal dangers** are a low intellectual and moral standard as a requisite for membership, and a failure to observe and conform to those rules of gentlemanly conduct among physicians commonly known as the "Principles of Ethics."

(2) **External dangers** are imposters seeking recognition from the profession, quacks and nostrum vendors who seek to prey on the public and the profession alike, lodge and contract practice, unjustifiable suits for damages, and numerous other conditions.

(b) **Usefulness.**—No excuse could be framed to justify the existence of a useless thing. Hence our societies will be known to the laity by the amount of good that they do. "By their works shall ye know them." The field of usefulness of, the County Society is two-fold:—

Read by title at the Topeka meeting of the Kansas Medical Society May 7, 8, 9, 1906.

(1) **To its members.** It should be a constant stimulus to its members, helping each individual bring out and develop the best there is in him.

(2) **To the public.** It should make itself the recognized authority in all matters pertaining to sanitation, hygiene, prophylaxis of epidemics, water supply, food and milk adulteration, school inspection, vulgar ads in papers, etc. If the society acts wisely and fairly, in these cases, its right to settle all these questions will soon be conceded by the public.

(3) **To both its members and the public** the society can be useful by being active in getting its own members into legislative bodies and being active in securing legislation of the pure food bill type. The average physician is probably not much of a law maker but the voice of the medical society, i. e. the medical profession, should dominate legislation pertaining to the practice of medicine and be paramount in all medical matters. Instead of the members of the State Board being appointed by the governor because of their political activity, they should be elected by the various state medical societies because of their superior fitness for the places. In like manner the county society should name the county health officer. That this arrangement would be eminently better and more satisfactory to every one except the professional politician-doctor, is generally conceded.

Every county society with fifty or more members should have a **home of its own**, which should include reference library, laboratory, free dispensary, a museum, and such other features as might be added. It should be open at all times to all the profession and meetings should be held at frequent intervals. Its work would include

(1) **The education of its members, and**

(2) **The drawing closer of the social band of union.**

As a rule the members of the county society can be divided into two classes

(a) Those that join in order to get into the higher bodies; these are generally drones.

(b) The workers that join for the benefit they can derive and give. Let us each ask ourselves, Which class do I come under? and if the answer isn't satisfactory to our conscience let us get right. How many of us have read the constitution and bylaws of our county societies? Get a copy and read it. Read the "Principles of Ethics." There is nothing contained therein that is so very difficult of execution. One of the greatest evils of the medical profession is the proclivity of some of our number to "knock" on his competitors. How much better for all if we could only stand together shoulder to shoulder and defend each other instead of being so ready to assail. There are many things that can be devised by

a wide awake society, that will interest,—get up an interesting clinic, attend postmortems as a society, put the screws to the chronic dead beat, squelch the advertiser and the quack, work together for the common good and you will be surprised to learn what a good world this is to live in after all. Remember that in union there is strength and without it all our efforts to emancipate the profession from the shackles that ignorance and prejudice have welded will be vain and futile.

Scientific medicine versus boarding houses in the treatment of the Insane. Dr. Kuhn, superintendent of the Farmington, Missouri, asylum for the insane appeared before the Jackson County Medical Society and demonstrated a remarkable similarity in the blood analysis of patients suffering from insanity to that of patients suffering from auto-intoxication and toxemia. Dr. Kuhn believes that the present method of conducting state institutions for the insane is simply a matter of running boarding houses for them and making them comfortable; and, as far as scientific medicine is concerned nothing is being done outside of the states of Illinois, Ohio and Massachusetts. He says that there is no demand whatever for scientific treatment and, that therefore, the superintendents of the institutions are simply farmers, engineers, or boarding-house-keepers. He believes that the so-called cerebral sedatives are entirely out of place in the treatment of the insane and states that at Farmington they have used less than \$10. worth in the last year. We have a great deal of sympathy for Dr. Kuhn's contention. In fact, we have long believed that insufficient progress was being made in the treatment of the insane, and, therefore, have so often suggested that the state of Kansas build a therapeutic hospital for the treatment of the acutely insane; and, put it in charge of the State University in order to train young physicians thoroughly in psychiatry and, put it under the influence of men who would be interested in really accomplishing something. We hope, that Dr. Kuhn will be enabled to continue his investigations of the physical condition of his patients until he shall have established certain laws governing the different mental diseases. Thus far, he has found in the hopeless cases a high percentage of eosinophiles in the blood with a low percentage of red cells; and, in cases of acute exacerbation, a high percentage of polymorphonuclears.

Book Reviews.

Woman—a treatise for medical students and practitioners by Bernard S. Talmey, M. D., Gynecologist to the Metropolitan Hospital and Dispensary, N. Y. Stanley Press New York 1906. Pp 228, 20 Illus., Flexible cover, Price, \$3.00.

Of all the books dealing with the sex problem, which have come to our notice, this is the most satisfactory. It deals with the matter in a scientific spirit—one of neither prudery nor prurience. The standpoint is that of the medical practitioner who wishes to know how to handle these difficult cases. The book is therefore dignified and worthy of a place in the library of every man who must act as a counsellor in family affairs.

Since the book is essentially a compilation, we do not find it replete with wild or radical theories. We have, therefore, nothing to criticize as to the author's views. The author has shown remarkable diligence in going over the literature of the world—ancient and modern—both in English and apparently also in the original tongues. The author's evident command of the classics has added a pleasure to the perusal of the book.

We are only sorry that some active medical publishing house did not bring out the book; because, now there is danger lest all do not learn of its merits.

A Text-Book of Diseases of Women. By J. CLARENCE WEBSTER, M. D. (Edin,) F. R. C. P. E., F. R. S. E., Professor of Obstetrics and Gynecology in Rush Medical College, in affiliation with the University of Chicago. Large octavo of 712 pages with 372 text-illustrations and 10 colored plates. Philadelphia and London: W. B. SAUNDERS COMPANY, 1907. Cloth, \$7.00 net; Half Morocco, \$8.00 net.

A good text-book for students. The anatomy and embryology are beautifully given. The various pathological conditions are sketched succinctly,—but, in sufficient detail for beginners. The author does not try to outline all possible methods of treatment for each disease, but gives what he thinks is best. It is a contrasting book to Kelly's Operative Gynecology, which of course, is not adapted to undergraduates but to specialists. It is interesting to note that Dr. Webster does not mention (except at the beginning) the Apostoli method upon which Massey lays such great stress, in his discussion of the methods of treating metritis.

This book brings to mind the tendency to reduce gynecology to a smaller place in the medical curriculum than it held a few years ago. Dr. Webster is professor both of gynecology and obstetrics at Rush; and, therefore, gynecology assumes in that institution its proper relationship to obstetrics. The study of the diseases peculiar to women should not be a branch of surgery; if it must be made a distinct specialty, let its followers be trained to other forms and means of therapeutics, as well as those of the knife. The best methods of treatment today are the conservative, where etiology and habits of life are corrected, before the knife is resorted to. By those who believe as we do in the rational treatment of the female genitalia, Webster's text-book should be the one offered to the students.

The book is beautifully gotten up. We congratulate both the author and the publisher thereon.

A Practical Treatise on Materia Medica and Therapeutics, with Especial Reference to the Clinical Application of Drugs. By JOHN V. SHOEMAKER, M. D. LL. D., Professor of Materia Medica, Pharmacology, Therapeutics, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia; Physician to the Medico-Chirurgical Hospital; Member of the American Medical Association; Fellow of the Medical Society of London, etc., etc. Sixth Edition. Thoroughly Revised. (In Conformity with the Latest Revised U. S. Pharmacopoeia, 1905.) Royal Octavo, 1244 pages. Extra Cloth. Price, \$5.00 net. Full Sheep. Price, \$6.00 net. F. A. DAVIS COMPANY, PUBLISHERS, 1914-16 Cherry Street, Philadelphia, Pa.

This is the work of a compiler rather than that of an original worker and thinker. It belongs therefore to the older class of text books, of which perhaps Potter's is the best example. The contrasting class is made up of such texts as Wood's (who is the dean of the newer school), Cushney's, and Sollman's. Compared then with Potter's text, Shoemaker's seems less encyclopediac.

We do not find Cloetta's work on digitalis discussed in this volume. In discussing the therapy of digitalis Shoemaker quotes from the Lancet of 1898, but fails to note the important articles in the same journal in 1906.

The devotion of pages 927 to 1158 to physiological therapeutics was in the old editions helpful. But now entire volumes are being given to each of the various subjects therein treated. The writer's own experience has been that Shoemaker did not give enough on these subjects to be helpful to him and he believes that it no longer adds to the value of the book.

Conservative Gynecology and Electro-Therapeutics. A Practical Treatise on the Diseases of Women and their Treatment by Electricity, B. G. BELTON MASSEY, M. D., Attending Surgeon to the American Oncologic Hospital, Philadelphia; Fellow and ex-President of the American Electro-Therapeutic Association, etc., etc. Fifth, Carefully

Revised Edition. Illustrated with Twelve (12) Original Full-page Chromo-lithographic Plates of Drawings and Paintings, Fifteen (15) Full-page Half-tone Plates of Photographs made from Nature, and 157 Half-tones and Photo-engravings in the text. Complete in one Royal Octavo Volume of 467 pages. Extra Cloth, Beveled Edges. Price, \$4.00 net. F. A. DAVIS COMPANY, PUBLISHERS, 1914-16 Cherry Street, Philadelphia.

It is difficult to evaluate such a book as this, because the author gives only one side of the story. To balance it one must have on the shelf beside it some other good text, such as Ashton's, wherein the various methods of treatment are put into their proper relative positions.

We must criticize the book as being somewhat vague in its directions for treatment. Thus in that difficult disease, metritis, we fancy that only a small percentage of cures would result if the physician did not utilize a vast amount of extraneous information. This text gives simply a few points regarding electric treatments. The diet, the hydrotherapeutic measures, the massage, and the drug therapy all are passed over so lightly that the reader does not secure a correct perspective of the treatment.

The book is valuable therefore simply to offset the operative tendency of modern gynecologists, when the gynecologist uses physical therapy as often as surgery and has text books embodying such views of gynecology, Massey's book will not be needed.

Diseases of Children by G. M. Tuttle, M. D., attending physician to Saint Luke's Hospital, the Martha Parsons Hospital for Children and the Bethesda Foundling Asylum St. Louis, Mo., New (No. 2) Edition, thoroughly revised. A volume of 392 pages and 5 plates. Cloth \$1.50. One of Lea's Series of Pocket Textbooks, edited by Bern Gallaudet M. D. Lea Bros. & Co.

While entitled "Diseases of Children" four chapters are devoted to The Infant at Birth, Normal Development of the Infant, Examination of the Child and Infant Feeding. Only those diseases of childhood up to the time of adolescence are exhaustively treated, those diseases not differing from the same diseases of adults being but briefly described so that all of the essentials of pediatrics are present in one volume. Much of the material is compiled from standard textbooks on pediatrics and "The aim has been to present the subject in a systematic, orderly form and in as few words as possible, both of which conduce to ease of study and reference." The book is an excellent one when the main facts are desired. Each disease is treated as to definition, etiology, pathology, symptoms and treatment, devoting in all cases little space to pathology and more to the symptoms and treatment.—S. C. E.

Surgical Suggestions by W. M. Brickner, M.D. and E. Moscovitz, M. D. published by the Surgery Publishing Co., New York. A little book of 60 pages bound in cloth and full of many practical suggestions

both in regard to diagnosis and treatment. For instance, the idea that it is easier to extirpate a cyst completely if it has first been injected with methylene blue or paraffin, is a good one. The book contains many methods and means which one would probably overlook unless ones attention was called to them. It costs only \$.50.—S. C. E.

Plaster of Paris and How to Use It is another book written by M. W. Ware, M. D. Instructor in the New York Post Graduate School published by the Surgery Publishing Co. There are 72 illustrations and about 100 pages. Cloth \$1.00. This book is especially good because it treats the subject in detail from a practical standpoint. It is concisely but comprehensively written and embraces a store of facts and method in one volume previously available only by reference to many books on allied subjects. One chapter is devoted to the use of plaster of paris in dentistry.—S. C. E.

Reprints.

1. Malignant and Nonmalignant Growths. By W. S. Bainbridge, M. D. New York. Reprinted from the American Journal of Surgery, August 1906.
2. Clinical Lecture on Malignant and Nonmalignant Growths. By W. S. Bainbridge M. D. New York. From The Atlanta Journal-Record of Medicine, June, 1905.
3. Brief resume of the World's Recent Cancer Research. By W. S. Bainbridge, M.D. From The Medical Record, Sept. 1, 1906.

Morphin-Scopolamin Anesthesia seems to be proving itself too dangerous for general use. Recently the Abbott Alkaloidal Co., has introduced a hypodermic tablet of hyoscin hydrobromid 1-100, morphin $\frac{1}{4}$, and cactin 1-6. This hyoscin is claimed to be different from scopolamin and infinitely safer. The Journal of the A. M. A. gives both sides of the argument on the claims of the Abbott Co., in its issue for January 26. Emory Lanphear is the chief exponent for the Abbott combination, and since he is well known to Kansas, his evidence can be rated by our readers themselves. But before using the anesthesia indiscriminately every one should read the discussion in the Journal of the A. M. A. We should hear both sides before endorsing either Dr. Wood's or Dr. Abbott's position.

Jottings.

Kargon. The following clipping from the Topeka Capital was sent us with the request to tell what "Kargon" is. The headlines above the clipping occupy as much space as the body of the article, showing that it is a well gotten up advertisement.

Cut this out and put in some safe place, for it is valuable and worth more than any thing else in the world if you should have an attack of rheumatism or bladder trouble or any derangement of the kidneys whatever.

The prescription is simple, and can be made up by anyone at home. The ingredients can be had at every good prescription pharmacy and all that is necessary is to shake them well in a bottle.

Here it is: Fluid extract dandelion, one-half ounce; compfound Kargon, one ounce; compound syrup of sarsaparilla, three ounces.

Take a teaspoonful after each meal and at bedtime. A few doses is said to relieve almost any case of bladder trouble, frequent urination, pain and scalding, weakness and backache, pain above the kidneys, etc. It is now claimed to be the method of curing chronic rheumatism, because of its direct and positive action upon the eliminative tissues of the kidneys. It cleanses these sponge-like organs and gives them life and power to sift and strain the poisonous waste matter and uric acid from the blood relieving the worst forms of rheumatism and kidney and bladder troubles. The extract dandelion acts upon the stomach and liver and is used also extensively for relieving constipation and indigestion. Compound sarsaparilla cleans and enriches the blood.

As you or any one of your family, especially the old folks, may be attacked at any time it would be wise to cut this out and save it,

A well-known local druggist is authority that this prescription is safe to use at any time.

Mix it yourself.

Professor Sayre of the School of Pharmacy has given us the following account of the "fake."

This 'fake' came to Kansas about three weeks ago. Since that time I have had no end of inquiries over 'phone and wire, asking what 'Kargon' is. Since this advertisement appeared in the Lawrence Journal there has been, I am told a stream of people, including some Professors (think of it!) getting these prescriptions filled, which means the fools are not all dead yet.

I have replied to the 'phone and wire messages regarding this preparation that it is a f-a-k-e. To be more specific to you I would say that 'Kargon' is one of the neatest little frauds that has come to light for some time. It is made by the Kargon Extract Company, Cincinnati, Ohio, formerly Covington, Ky. It is a preparation that has its rade mark, containing 18 per cent. alcohol, guaranteed under the Food and Drug Act tJune 30, 1906, Serial No. 108. It is advertised as valuable, soothing, healing, cleansing tonic, vitalizing agent to the entire kidney, bladder and urinary tract and generative system, indicated in all forms of diseases affecting these organs. Also indicated in Bright's disease, diabetes, dropsy, etc., etc

Now what are you going to do about it? I begin to be disgusted. These fakes were common in the East, but this kind of fake never before to my knowledge, appeared in the West. It seems to me that our only salvation against such frauds is to form a combination against them, composed of respectable physicians and pharmacists. I am telling the people here in Lawrence that I am ashamed to own that such a preparation could be sold at all right under the nose of the Pharmacy Department.—L. E. SAYRE.

The Independence Hospital and Sanitarium. --- Recently, the Journal published a clipping from the Independence papers reciting the wonderful work done by this hospital in treating some case which had apparently, up to that time, been neglected. This clipping was sent in by a prominent member of the Kansas Medical Society with the note which was printed in connection with it, calling attention to the fact that the operation was not so wonderful; and, that the whole matter was in bad taste. The head of the hospital, Dr. Shelton, now writes stating that he believes some injury may come to him and the institution because of our publication. We have told him that we are not of that opinion; that the article could not help but to do him good and put him in the right light before his colleagues, because it would enable him to reply definitely to the insinuations that he was using the lay press to exploit himself. We quote from Dr. Shelton's letter this explanation of the appearance of the article in the paper. It is as follows:

"Regarding this particular article, the reporter was visiting the hospital soon after the opening, at which time the boy mentioned was a patient, and the mother of the boy (who was with him) gave the reporter the information upon which his article was written. It was written and published without my knowledge or consent. The reporter mentioned in the article that another patient, who previously had been taken to Kansas City to the hospital with diseased bone, had undergone an amputation to save her life. His object in making this statement, he says, was to show the advantage of having a hospital close at hand, that many cases might be saved if operated upon at once which if compelled to go a great distance might not survive an operation. His intention was to say a good word for the hospital and not to give discredit to any one who might have been connected with the other case.

"In his description of the patient he made it appear that the patient was in a very critical condition at the time of the operation, which was not the case; the operation being simply to remove the sequestrum which involved the tibia and the tarsal bones, the involucrum having already formed. In the article he confused the description the mother gave him of the condition of the boy at the onset of the disease seven months previous, with the condition at the time of the operation. Neither the mother nor the reporter attempted to discredit anyone for anything regarding the case, as the party making the comments would believe; there was no occasion to do so. The only physicians connected with the case were with me in consultation at the beginning when we were called too late to operate more than to relieve the pus, as there was already separation at the lower diaphysis of the tibia, the mother having treated the case for rheumatism for more than a week; and, those who assisted with the operation were Drs. J. T. Davis and H. W. Graves. I should be pleased to have you write either or

both of these, should you so desire. You are probably quite aware of the fact, as illustrated by this article appearing in the Journal without my having an opportunity to state my version, that one should not be held responsible for everything appearing in the newspaper. The object which the reporter had in writing the article, he says, was to say something favorable for the new hospital; he had no thought of advertising me in the least. I should like very much to have you write Mr. H. G. James, editor of the paper, regarding this article, regarding anything you may wish to substantiate in this article as to my attitude on the question of newspaper advertising."

Now, we think that this exonerates Dr. Shelton quite thoroughly; and, we take the opportunity to call attention to the fact that a large part of the appearances in public print of names of physicians is due to the zeal of the newspapers themselves rather than the perverted energy of the physicians mentioned. This condition of affairs makes necessary a greater care on the part of critics; and, a greater charity on the part of competitors. If a physician is not trying to find some fault in the character of his colleague, he is not apt to bring such things as unfortunate newspaper comment into the lime-light of publicity.

On the other hand, a cultured physician is not likely to have his name brought out prominently in connection with medical work more than once. That is, —some newspaper may drag him out and exploit him once, but if the same newspaper does it the second time, then the rest of the medical world is justified in suspecting a weak fondness for newspaper notoriety. So, while we feel justified in publishing from time to time unfortunate items from all over the state; we do it without wishing to cast discredit on the physician so unfortunate as to be connected with such newspaper items; and, we do it with the hope that this calling attention to the bad taste shown would prevent a recurrence of similar trouble.

In conclusion, we feel sure that Dr. Shelton's colleagues may rely upon his probity and modesty; and, that they may unite with him safely in promoting the welfare of the Independence Hospital and Sanitarium.

"W. B. Saunders Company, of Philadelphia and London, have just issued a revision of their handsome illustrated catalogue of medical, surgical, and scientific publications. Beyond question this is the most elaborate and useful catalogue we have ever seen. The descriptions of the books are so full, the specimen illustrations are so representative of the pictorial features of the books from which they are taken, and the mechanical get-up so entirely in keeping with the high order of the context. The authors listed are all men of recognized eminence in every branch and specialty of medical science. The catalogue is well worth having, and we understand a copy will be sent free upon request."

VENEREAL DISEASE.

(A discussion suitable for handing to the laity.)

Because one quarter of the population of such cities as Paris, Munich, New York, etc., are or have been affected with venereal disease, because 40% of barren marriages are due to gonorrhea, because venereal disease is determining who shall constitute the future generation of this nation, it is needful for the laity to learn at least the elements of the disease.

Venereal disease is of two distinct forms, the one local, the other constitutional in its effect on the body. The local disease is gonorrhea, the constitutional is syphilis.

These diseases are as old certainly as civilization and mark the effort of man to rise above the beast, for wherever moral degeneracy is most abundant, these diseases reign. Gonorrhea is caused by a diplococcus (gonococcus) which is able to set up an inflammation in mucous membranes. It then burrows in the pits and glands of the membrane and is practically ineradicable. Its symptoms are swelling and profuse discharge of pus. These symptoms subside so that in the chronic form there is only a watery discharge now and then, with only slight tenderness and inflammation. Of course the disease attaches chiefly the genital organs, though cases are found where the mouth, nose and rectum are the primary seat of the disease. In the male the germs work their way upwards to the glands and the bladder, and may reach the blood to set up acute inflammatory rheumatism of the worst type. When the germs reach the glands sterility is the usual result. At any rate these germs will lie dormant for years only to be aroused by some weakness or excess and then they would be transmitted to the innocent wife, to make of her a semi-invalid.

In the female the germs does not cause so much pain and discomfort, but they do even more damage, because they settle in the glands and tubes of the genital tract and result in barrenness on the one hand, and in frequent inflammations and abscesses on the other. A very large percentage of the gynecological surgery is made necessary by gonorrhea. Hence for the woman the after-effects are even worse than for the man.

Syphilis, on the other hand, causes very little local disturbance—a mere sore or ulcer at the point where the virus enters the system, but after two or three months the body breaks out with coppery papules and similar eruptions and we know that the whole body is affected. Still later tumors appear in the mouth and nose, for instance, where they break down into ulcers; in the brain and nervous system, on the skin,

or in the internal organs such as the liver. Hence years after the disease first appeared one may see its effects in the way of a locomotor ataxia, blindness, insanity, or othersore affliction. It may be transmitted to the children (if it does not cause abortion or death of the unborn fetus) and thus carry the curse to the second and third generation.

Persons suffering with gonorrhea or syphilis should of course sleep alone. Their beds should be made with the hands protected by gloves or thoroughly aired without handling until all stains are thoroughly dry. The towels and wash cloths should not be used by any one else. The virus is infectious only when not entirely dry, hence in only a few cases is the trouble communicated except by sexual intercourse. Hence also the disease points to unholy living with all that this expression might mean. Naturally therefore venereal disease will continue until prostitution ceases, and prostitution will continue until the race is regenerated and learns that continence is not unhealthy and that the same law of purity holds for man as for woman.

One of the greatest evils resulting from gonorrhea is the infection of the eyes of babies. This may occur during birth or from the unclean hands of the caretakers. More blindness is probably due to gonorrhea than to any other one disease. This infection of the eye demands the most active as well as the most skillful treatment.

It is the duty of every right minded person to spread the principles of personal purity, and the knowledge of the evils of prostitution and fornication abroad wherever his influence is felt.

The Anemias of Childhood. The anemias of early life are equally sequels of the acute diseases common to this period. The exanthemata are especially liable to be followed by a depreciation of blood quality, and a protracted convalescence often depends on this one condition alone. Moreover, the frequency with which physical stigmata or infirmities actually date from an attack of measles, scarlet fever, diphtheria or any of the other similar diseases of childhood, can often be properly laid at the door of insufficient or improper care during the very important stage of convalescence from these diseases.

It should be recognized that the hematogenic function while exceedingly active in childhood, is yet very susceptible to all influences, among which the toxins generated in the course of the acute diseases are most common. When a storm infection of measles, scarlet fever or any of these similar ailments is passed, there must follow a period of reconstruction. If the danger has been slight as a result of a light storm or an unusually strong structure, the reconstructive process places little demand on the resources of the individual. But if the storm

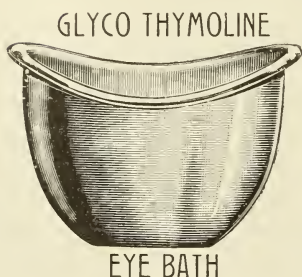
has been unusually severe and the structure ill-prepared to meet its fury, the rebuilding process is certain to be long and laborious. Deficiency in the quality of the blood is one of the greatest handicaps at this time, and the clinician should recognize this as one of the most important indications for therapeutic assistance.

The action of Pepto-Mangan (Gude) is always very marked in these cases, and it is interesting to note how rapidly children respond to its upbuilding influence. A marked increase in hemoglobin at once follows its use and the red cells multiply rapidly. With improvements in the blood constituents there is a corresponding increase in the whole bodily tone, and it only takes a few days to carry the average patient safely away from the dangers of a trying period.

Pepto-Mangan (Gude) is therefore a very valuable tonic in childhood, and unlike so many of the ordinary hematinics it can be given with impunity to the youngest infant. It has marked alterative properties, and in strumous or marasmic conditions it is especially valuable. It is absorbed rapidly, and is never rejected by even the weakest stomach.

In early life its administration is best effected by giving it in milk, and the dose should range from ten drops to two teaspoonsful, depending, of course, on the age of the patient.—Adv.

A sterile eye bath. An eye bath fashioned from a single piece of aluminum has been introduced by the Kress & Owen Company.



That this little device will be well received by the medical profession is not to be questioned when one considers the many points of advantage this metal cup has over the old style glass contrivance. It is cleanly, unbreakable and can be sterilized instantly by dropping into boiling water. The surgical bag in the future will hardly be complete without one of these cups, which will give happy results in many an emergency. It will be found invaluable for treating ophthalmia, conjunctivitis, eye strain, ulcer-

ation and all inflammatory conditions affecting the eye.

DIRECTIONS.—Drop into the eye bath ten to thirty drops of glyco-thymoline, fill with warm water; holding the head forward, place the filled eye bath over the eye, then open and close the eye frequently in the glyco-thymoline solution.

No pain or discomfort follows the use of Glyco-Thymoline. It is soothing, non-irritating, and reduces inflammation rapidly.—Adv.

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PRESIDENT UHLS.

DR. LYMAN L. UHLS,**Our President, 1906-7.**

Dr. Lyman L. Uhls was born on a farm near Chester, Ill., March 25, 1857. He grew up to manhood on the farm, working during the summers and attending the district school in the fall and winter months. After completing the course of study in the common schools, he took higher studies in a school at Sparta, Ill. He then taught four terms of district school in his native county; then taught one year at Sparta. He graduated from Rush Medical College in class of 1884. Was married to Anna Bean, a playmate of his childhood, in 1883. They have two children, one daughter now in college, and one son in high school.

His life on the farm was a strenuous one,—hard work and but little play. However he was fond of athletic sports. His ambition was to excel his companions in wrestling, running and jumping. He carried this spirit into his work. He always tried to lift a bigger log, plow a straighter furrow, cradle a wider swath, than the others. Immediately after he was graduated in medicine, he located at White City, Morris county, Kansas and engaged in general practice. At that time the Kansas air was full of politics. The doctor was a physician, a Presbyterian and a republican. And it appears that his theories, creed, and principles harmonized, for he was always found in excellent humor; was respected by his medical colleagues, who made him president of the Central Kansas District Medical Society; held in high esteem by the members of his church, who sent him to represent the church in the National council and also held a high seat in the councils of his party. He practiced at White City seven years, then moved to Gueda Springs, Sumner county, where he practiced four years, then left to take the position of assistant physician in the Osawatomie State Hospital. He held this position two years, when the political upheaval of 1896, turned all the republicans out of the state institutions. He went to Paola, Kansas, and again engaged in general practice of medicine. His two years experience in treating the insane, attracted him to the study of mental and nervous diseases, and he became proficient along this line and when in 1899 the republicans had regained control of the administration, Dr. Uhls was appointed superintendent of the hospital where he had formerly served as assistant. He has since held that position. As a superintendent he is very popular, possessing a pleasing manner, quick perception, executive abilities, and last but not least, a good stock of Common Sense.

L. R. S.

OPERATIVE INTERVENTION IN ECLAMPSIA.

GEORGE CLARK MOSHER, M. D.

Professor of Obstetrics, University of Kansas.

Kansas City.

Operative intervention in eclampsia resolves itself into a very nice calculation of the elements of risk involved. The absorption of toxins threatens the life of the patient, by their continued accumulation. The necessary shock to which *accouchement force* exposes her incites to convulsion, due to irritation of the nervous system.

No other point in obstetric art is so very dependent on the practitioner's being able to weigh these contrasted dangers at their correct values.

Accouchement force, in the early days of surgical interference, meant a rough and brutal exhibition of the end justifying the means, and consequently, many deaths could be traced directly to the maternal traumatism of the operation itself.

Under modern methods of technique, this becomes less objectionable, and some of the leading teachers abroad and most of our own countrymen now endorse the surgical treatment as rational and conservative.

During the pre-eclamptic state, the symptoms which point to artificial interference are: rapid pulse, generally associated with high arterial tension; gastro-intestinal disturbances; lassitude; headache; decrease of all excretions, either rapidly or more slowly, the class of symptoms to be associated with intoxication through some infective absorption.

We always carry with us three classical prodromes of eclampsia; frontal headache—unilateral—visual disturbances, and epigastric pain.

When we consider that Green's Tables show a maternal mortality in ante-partum eclampsia of 46 and foetal of 69, in intra partum of 25 for each, in postpartum, maternal of 7 per cent, the suggestion is clear that the chances of the eclamptic subject are immeasurably improved as soon as the uterus is empty.

If, in the face of all medicinal measures, the five eliminative processes are inadequate, so that the index of urea is steadily downward, and the amount of albumen steadily increasing, our duty is plain.

It is rather remarkable that the British school of obstetricians, and such German teachers as Winckel, and among the French, Charpentier, all oppose the emptying of the uterus in the pre-eclamptic state, fearing that the irritation, resulting from the dilation of the cervix, might precipitate the convulsion.

The opinions of such authority must be given their due weight, but American practitioners are usually in favor of the prompt emptying of the uterus. In the second stage of labor, there is practically unanimity, provided full dilatation is first secured. In the pregnant state, and in the first stage of labor, where the undilated cervix offers a complete barrier, the palliative method, when selected, will be followed by foetal death, the maternal mortality being 35 per cent.

As over 90 per cent of cases recover immediately after the uterus is empty, the delivery being accomplished early in the attack, it must be conceded, that the expectant plan, advised to avoid irritating the eclamptic uterus, should be condemned as being timid, irrational, and non-surgical.

When it has been decided that, a given case, operative treatment is indicated, the choice can be defined as among the following:

1st. Caesarean section.

2nd. Mechanical dilatation of the cervix by any method.

3rd. Dührssen's multiple incisions, immediately breaking down the barrier of the cervix.

4th. Combination of mechanical dilatation and deep incisions.

Caesarean section in the hands of skilled operators, familiar with the method, and having every hospital facility, gives a maternal mortality of 36 per cent., — a mortality due to shock, atony, hemorrhage, and auto-infection.

In these limited, select instances, the results compare favorably with the best treatment not surgical. However, the average physician has neither careful training nor hospital to promise him the brilliant statistics of those who set the pace in making records. His case has the double danger of lack of equipment, and greater chance of infection, being conducted in the home without ideal surgical environment. Moreover the atonic condition of the uterine muscle, making possible a fatal hemorrhage, and the irritation of the scar, uterine, as well as abdominal, and that associated with the peritoneal inflammation surrounding the sutures in the uterine walls, predispose to future eclamptic attacks.

The second method, that of mechanical dilatation and delivery, is the favorite in my hands. In two cases which I have delivered lately, this was the method adopted, and the results were entirely satisfactory. Both patients remain apparently well at present.

The first came on in the sixth month in a patient who had suffered a pregnancy nephritis ten years ago, being delivered at term in eclampsia. In the present pregnancy as soon as the urine showed a large percentage of albumen, being two grammes to the litre by the Esbach test, a daily urinalysis was made. At six and one half months, a profuse hem-

orrhage occurred the patient being blanched from loss of blood, the foetus still viable. Digital examination detected a boggy mass low down in the left side, from which, and the symptoms of bleeding, the diagnosis of left lateral placenta praevia was made. There was no dilatation, and with the hope of carrying the case to the 7th month, in interest of the child, the vagina was packed with gauze, left twenty-four hours and removed. Not a stain appeared, nor did it recur for ten days, when the albumen suddenly disappeared from the sample, foetal heart sounds not discernable, no foetal movement perceptible. Diagnosis of death of the foetus was made. Hemorrhage again set in. A rapid bimanual dilatation under deep anaesthesia was done. The rupture of the membranes disclosed a prolapsed cord, pulseless. Version easily followed. The forceps to the after coming head completed the delivery. Shock was severe, and nausea with black billious vomit kept up for twenty-four hours; urine scanty; albumen increased again for two days. The symptoms improved and the patient made an uneventful recovery.

In his case the dilatation was somewhat difficult, owing to the unpreparedness of the cervix to give away, but with the anaesthesia in competent hands, complete relaxation gave every opportunity for rapid work which was completed in twenty minutes.

The second case was one which I had delivered after induction of labor, in consultation with the family physician two years ago. Her physician having in the meantime, taken an official appointment, and being out of the city, she consulted me at his request.

Knowing what had been suffered in the former pregnancy, this was watched with great anxiety. No albumen, no casts, no oedema showed until ten days after term, but a fibroma, the size of a small orange, came to the front with the development of the uterine mass.

The delivery in this case also began with hemorrhage, due to the separation of the membranes from the lower uterine segment, the placenta being normally planted.

The cervix, undilated, was also, in this case, made to disappear under anaesthesia, and the head engaging with uterine atony, the forceps were applied and a living child born.

In each case, the pulse of the pre-eclamptic state was 120 to 130, and continued for some three days following delivery, except when kept under by exhibition of *veratrum viride* in dose of 3 to 15 drops.

I mention these cases, being recent, and being at present on the way to convalescence. In neither were casts found, although albumen was very marked, and the kidney insufficiently alarming, one case only eliminating 8 ounces in 42 hours.

As to the operation of Dührssen, that of the deep multiple incisions

I have never adopted this expedient but can readily see why it might become a choice of technique in cases demanding rapid extraction, where the interests of the mother and the child demand hasty interference.

The dilatation by Bossi dilators, and the deep incision to remove at once all barriers of the cervix should be the safeguarded in such cases, Bossi dilators render the management of the dilation stage mathematical and rapid. Judiciously used they are perfectly safe.

The operative treatment in eclampsia where undue haste is used, the attempt being made to drag the foetus through an internal os not fully dilated, is the **bete-noir** of the inexperienced obstetrician. No doubt, many mothers perish from ruptured uterus, because in eclampsia where the supra vaginal portion is found rigid until the beginning of the labor, the delivery is effected by sheer force rather than by art.

It is on account of the dangers of deep lacerations of the maternal soft structures, that one must wait for dilatation and disappearance of the cervix before attempting *accouchement force*; and during this time experience proves to me, the great value of veratrum viride as a remedy that does things.

To conclude intervention is always recommended in intra-partum eclampsia with dilated cervix, in late pregnancy, and in the first stage of renal insufficiency with full bounding pulse, albumen 10 of 12 per cen. The choice of method should be rapid dilatation of the cervix and then forceps or version to complete delivery. Very rarely the deep incisions of Duhrssen will be indicated.

Halbertsma's method of the ante-mortem caesarean section is not endorsed by American teachers except in deformed pelvis or on a moribund mother, the foetal heart being perceptible.

Each case of eclampsia brings its own perils, and each must suggest the time and method of mechanical intervention.

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APPENDICITIS DURING PREGNANCY.

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Some months ago my attention was drawn to the subject of appendicitis during pregnancy by the following case:

April 17, 1906—Mrs. W., 23 years old, the mother of a healthy 3-year old boy, consulted me because of pain and persistent soreness in the region of the right ovary. She stated that ten days previously she was walking along the street near her home, when she was suddenly attacked with severe pain in the region of the pelvis and right ovary, and which was so severe that she nearly fell to the street. She got home with great difficulty, however, and went immediately to bed. A physician was summoned, who applied an ichthyol vaginal pack and hot fomentations. This caused so great discomfort that the pack was removed. The pain somewhat subsided, but the tenderness and soreness continued.

An examination ten days after the attack showed very rigid abdominal muscles, and a point of exquisite tenderness low down in the region of the right ovary. By vaginal examination a distinct mass was made out in the right ovarian region, and also the left ovary could be easily felt. It was about the size of a small orange, apparently cystic. There was great tenderness on examination, particularly the right side. The cervix was soft; the uterus enlarged; and the vaginal mucous membrane was dark in color. There had been no morning nausea, but the breasts were enlarged and tender.

A diagnosis of extra-uterine pregnancy was made with probably partial rupture of the gestation sack. Immediate operation was advised.

The following morning under ether anesthesia, Drs. Trexler and Knipe assisting, a median incision was made through the edge of the right rectus muscle. There was no extra-uterine pregnancy. The left ovary was enlarged, and contained a normal cyst of the corpus luteum of pregnancy. The right ovary was enlarged about the size of large walnut, and cystic. This was removed. The appendix was found pointing downward and inward over the brim of the pelvis. It was enlarged and club shaped, and adherent to the right ovary and to the intestines. It had not ruptured and was easily removed. The wound was closed without drainage. Primary union resulted. On the sixth day after operation the patient aborted. The foetal tissue indicated a pregnancy of about three weeks' duration.

This unexpected discovery of an appendicitis associated with pregnancy, brought the question to my mind, that possibly these conditions not infrequently complicate one another. On this point, however, the literature is unusually silent. Many writers on obstetrics and surgery mention appendicitis as a complication, but none, that I have been able to find, mentions its frequency. In order to determine this point in a relative way, I took occasion to write six of our prominent obstetricians and surgeons for their experience in this connection. The result was by no means uniform, or indicative of a definite conclusion. Out of 2000 cases of labor I was unable to find more than ten cases of undoubted appendicitis recorded; and of this number only 2 were operated on during pregnancy; one at the fourth and one at the fifth month. Both were of the catarrhal type and both recovered.

The experience of the various practitioners consulted was remarkable in its variety. One reported two cases in 250 pregnancies; and another never had seen a case in almost 1000 labors. This great discrepancy comes from the fact that often an appendicitis is mistaken for a right tubal disease; nor is this diagnosis easy. How completely one condition may mask another is demonstrated by my own case herein reported. The character of the practice also may differ widely among individuals;—the general practitioner and obstetrician seeing unquestionably more cases of normal labor than the gynaecologist or surgeon.

In the past few years it was thought that appendicitis was much more common in men than women; but with the increase of our knowledge of the disease and our more accurate methods of diagnosis, statistics on this subject have been markedly changed. In the earlier editions of Deaver's work on appendicitis, he stated that 80% of all cases occurred in males; but in the last edition, he very materially modified this opinion. In 3,000 cases operated on by himself, there were only about 60% male to nearly 40% females. Einhorn, (quoted by Dr. McRae,) in 18,000 successive autopsies found perforating appendicitis in 55% of males and 57% of females. Robinson, (quoted by Deaver,) in 128 autopsies found evidence of past peritonitis, on or about the appendix in 68% women, and in 56% of men. Sounebery found 40% of his cases were in women. Hermes found in 1577 cases of appendicitis in Berlin, 40% were females. The contention that this per cent should even be greater in women, seems reasonable, as in many cases of abdominal pain in the right iliac fossa are referred to the "tubes and ovaries" often without warrant. This opinion is also supported by the fact brought out by McRae that in almost all cases in women, the attack of appendicitis occurred at or near the menstrual period. In fifteen operations for appendicitis in women, he observed 4 cases, over 25%, in which there was also distinct disease of the right tube and ovary.

When we consider that over 61% (61.63% Deaver) of all cases of appendicitis occur between the 20th and 40th year, and that at least 40% occur in women, it seems reasonable to affirm that a large percentage must fall within the period of gestation, and prove a serious complication of pregnancy. More careful diagnosis in the future will, I am confident, demonstrate the truth of this contention.

The mortality of operations for appendicitis, during pregnancy, has been in the past remarkably high. Futh states that out of 42 cases, which he was able to find on record, 22 of the women died, a mortality of 52.3%. He ascribes the gravity of appendicitis during pregnancy "to the displacement of the caecum by enlarging the uterus, bringing the appendix close to the liver or uterus." This is, undoubtedly, a factor in rendering the resulting infection more severe and operative interference more difficult.

Abortion, also, is a most important factor in the mortality. It is particularly likely to occur in all cases of severe inflammation or abscess formation. In Futh's cases, it followed in all but one of the 37 operated upon. He says, "If the tendency to abortion in these cases can be controlled by opium or other measures, it may be possible to save more of the patients with appendicitis during pregnancy."

While these conditions unquestionably influence the mortality; yet, to my mind, the question of delay is the real and vital one that determines the death rate. Why should not a pregnant woman with appendicitis have the same chance of recovery, as her non-pregnant sister,—early operation? I cannot but believe that she should have, and will have, if her case of appendicitis is considered irrespective of her pregnancy. The chance of abortion, after an early operation, is very small indeed; for the operation is then done before any extensive inflammation has involved the uterus, or an abscess has rendered the patient septic. The operative manipulation is very slight in a "clean case" and abortion from the anaesthetic alone very rarely results.

The operative wound in the abdomen will not prove a complication; most certainly not in cases where drainage has not been necessary; and even in those cases that are for a time only partially closed, the danger is slight, when compared with the benefits of certain removal of a real menace to life.

In considering the literature on this subject, and also my own limited experience, I am absolutely convinced, that early operation should be undertaken in cases of appendicitis in the pregnant woman, just as it should be in the non-pregnant state. By so doing, the mortality will not be 50% or more, but will be nearer 5 to 10%, depending solely upon those factors that influence it in the general run of abdominal surgery.

THE PREVENTION OF EPILEPSY.

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Epilepsy is, undoubtedly, one of the most serious diseases which afflict the human race. It is wide spread in its distribution, chronic in its course; produces both mental and physical deterioration; and is extremely intractable and unyielding to treatment. There are, in the United States alone, according to conservative estimates, 160,000 epileptics, of whom a large number are more or less enfeebled mentally, and the great majority are hopelessly incurable. The percentage of incurable cases of epilepsy is variously estimated by different authorities, but is given by all as quite small. There are some observers who even go to the extreme of stating that epilepsy is incurable. While I cannot agree with such an opinion, I am inclined to a more conservative estimate than that given by some authorities of the first rank. I believe that not more than ten per cent of all cases of genuine established epilepsy are curable, under favorable conditions. Under conditions such as exist, with most patients allowed to drift into chronicity under the continued administrations of patent nostrums or other heavily loaded bromide mixtures, before seeking scientific treatment, the percentage is even smaller. Since the outlook in this direction is so discouraging, it behooves us to catch the spirit of the times and give more consideration to preventive measures.

Any comprehensive discussion of prophylaxis must necessarily include a discussion of causation as the successful prevention of a disease is always based upon a knowledge of its etiology. The causative factors in the production of epilepsy may be conveniently divided into two groups: the predisposing and the exciting. Belonging to the former may be mentioned heredity, age, dissipation, vicious habits, prolonged ill health, etc. and to the latter emotional shock, reflex irritation, intoxications, trauma and certain diseases of early life as infantile paralysis, meningitis, and reflex convulsions. The most important of all causes, predisposing or exciting, is bad heredity. Authorities differ somewhat in estimating the percentage of cases due to this cause, but all agree in placing it high. Binswager states that an heredity predisposition exists in between thirty-five and forty per cent of cases. Gowers places it at forty per cent and Spratling at fifty-six per cent. A study of my own cases shows that in those in whom a family history could be obtained forty-six per

cent had an hereditary predisposition to the disease. Among the diseases in the parent tending to produce epilepsy in the offspring there are three stand out prominently because of their greater importance. They are, in the order of their potency, epilepsy, alcoholism, and insanity. The respective percentages were found by Spratling in a study of one thousand cases to be, epilepsy sixteen per cent, alcoholism fourteen per cent, and insanity seven per cent. The influence of epilepsy and insanity in this direction is much more widely known and generally recognized than is that of alcoholism. The importance of the latter has not been given sufficient attention, nor has sufficient emphasis been laid upon it in its presentation to the public. The laity are inclined to look too lightly upon this danger of alcoholism or to doubt entirely its tendency to transmit disease. A study of the question, however, and a review of the statistics relating to it ought to convince the most skeptical. Demme, in a paper published in 1891, reports two groups of ten families which he had under immediate observation for a period of twelve years each. In one group the parents were drinkers, in the other they were abstainers. To the first group, the drinkers, were born fifty-seven children, of whom only ten, of 17.5%, were fully normal. The remainder suffered from various degenerative diseases, as deformities, epilepsy, chorea and idiocy. Twenty-five of the children died in the early months of infancy. To the ten abstaining families sixty-one children were born. Of these, only five died during the period of observation. Four children suffered later from nervous diseases, two were imperfectly formed, and the remaining fifty children, i.e. 81.9%, were healthy and remained so. Bourneville, in a study of two thousand five hundred and fifty-four children admitted to the hospitals of France, all suffering from idiocy, epilepsy, imbecility or hysteria, found that one thousand and fifty-three of them were the offspring of drunken parents, nine hundred and seventy three having drunken fathers and eighty having drunken mothers. It is unnecessary to multiply statistics, but suffice it to say that of the diseases transmitting an epileptic tendency, alcoholism is a close second to epilepsy itself.

Since the most important factor in the causation of epilepsy is a bad heredity, we must rely, in a great measure, for its prevention upon measures seeking to check the transmission of this tendency to its development. So long as criminals, degenerates, epileptics, imbeciles and confirmed drunkards are allowed to procreate offspring, so long must we expect a heritage of nervous weaklings. Those who have not taken occasion to inquire into the subject will be surprised at the number of such defectives who marry, and at the increase of disease resulting therefrom. At the risk of being prolix, I will mention a few statistics illustrating these points. Echeverria, the celebrated foreign alienist, re-

ports a study of the children of one hundred and thirty-three married epileptics. There were five hundred and thirty-three children born to these people. Of the children, one hundred and ninety-five died in childhood of convulsions; twenty-seven died quite young of other diseases, twenty-two were still born, seventy-eight were epileptic, eighteen were idiots, eleven were insane, thirty-nine were paralyzed, forty-five had hysteria, six had chorea, seven had strabismus, and only one hundred and five were normal and healthy. Dr. Knight, at the international congress of charities, corrections and philanthropy, in Chicago in 1893, reported a case of interest, illustrating as it does, not only the bad results of epileptics marrying, but also the error of allowing defective paupers to marry in order to relieve the state of their care. This was an epileptic woman who, although an inmate of a poor house, was allowed to marry a farmer who wanted a housekeeper. Sixteen children resulted from the union. Of these, seven died in infancy, but the remaining nine were all defective, some being epileptic and others mentally deficient. The recently published "Special Reports of Paupers in Almshouses," issued by the U. S. Census Bureau, contains some interesting data upon this subject. Of these 158,566 paupers whose marital condition was known, 73,105 were classed as married, widowed, or divorced. These figures are all the more striking when it is noted that the total number considered includes children as well as adults. Of two hundred and seventy-five epileptics at the Parsons State Hospital who had reached a marriageable age at the time of admission, 30.3% of the men and 42.8% of the women were, or had been married; and those of the same patients, 12.6% of the men and 25.7% of the women had married after the establishment of their disease. It is very probable that a larger percentage of marriages occur among epileptics whose opportunities have not been limited by institution life. A consideration of such statistics must impress one with the imperative demand for some restriction of the marriage of such people. Whether this can be accomplished better by means of statutory enactments or by a more thorough education of the public upon these matters is still an open question. As for myself, I heartily favor the former method. Critics of this plan raise the objection that such laws are impractical and unconstitutional. This criticism can be refuted by citing a recent decision of the supreme court of an eastern state upholding the constitutionality of such a law. One state, acting alone, cannot hope to reap the full benefit of such a method, but if each of the several states would take steps towards restricting the marriage of parties unfit to propagate children, and the people would see to it that these laws were enforced, it would, in my opinion, do more than any other one measure towards the checking of epilepsy.

Next in importance to hereditary influence in the etiology of epilepsy is apoplexy in infancy and early childhood. Under this head are included hemorrhages, emboli and thromboses, but the first named is very much the most frequent. The frequency of this lesion as a causative factor, in the production of epilepsy, has been very much underestimated by most authorities. The best observers, however, lay great stress upon it. Spratling gives infantile cerebral palsy as a cause of epilepsy in 11% of his cases, and he quotes in his book on "Epilepsy and its Treatment," Hughlings Jackson, than whom there is no better authority upon this disease, as saying that he considers small hemorrhages in the brain to be the most frequent cause of idiopathic epilepsy. Of those patients admitted to the Parsons State Hospital during the last biennial period, in whom a probable cause of disease could be ascertained 10.3% were cases of infantile cerebral palsy. Statistics relating to infantile palsies do not give an accurate conception of the frequency of infantile apoplexies in the causation of this disease as they are based upon cases only in which the lesion has involved the motor cortex or tracts. There are undoubtedly many other cases in which the apoplexy has occurred in other parts of the brain, leaving perhaps, no symptoms except the resulting epilepsy. Such cases are described by some authorities as infantile palsy without palsy. The apoplexy occurs, in a large percentage of cases at the time of a convulsion which itself is not an epileptic seizure, but has been brought about by some entirely different condition, such as hyperpyrexia, or reflex irritation from a deranged gastro-intestinal tract or overloaded stomach. The importance of apoplexy as etiological factor becomes especially apparent when we consider the gravity of the prognosis in epilepsy but to this cause, and the opportunity there is for preventive measures. No effort should be spared to prevent the development of a convulsion in infancy, or childhood. The old fallacy that infantile convulsions are comparatively trivial matters and no occasion for alarm should be refuted, and parents and nurses should be taught the possible danger resulting therefrom and how best to prevent their occurrence. The simple pyrexias of children should be watched more carefully than they usually are and the temperature should be reduced as soon as the premonitory symptoms of convulsions appear. Above all, parents should be made to understand the danger of indiscriminate and improper feeding of babies. Many a child has been made epileptic for life by suffering an apoplexy occurring during a convulsion due to reflex irritation from a stomach overloaded with indigestible food.

Emotional shock is a very frequent exciting cause of epilepsy, especially in females. The shock is more often in the form of a sudden fright, but it may be from terror or excitement. Few recognize the extent to

which the body, both in health and disease, is influenced by the mental state, or realize the danger of too violently playing upon the emotions. If these conditions were more generally known and better understood there would be less of that indiscriminate frightening of children, in which the weak and nervous is little short of criminal.

Teachers would do well to pay more attention to this subject, as disastrous results sometimes follow the injudicious administration of corporal punishment. A few years ago there came under my care a girl, who, although a nervous and timid child, had been healthy and bright mentally, up to her tenth year. At that age, while in school, she was whipped by her teacher for some trivial offense. Before the punishment—not a severe one—had been concluded the child fell in a convulsion, the beginning of a well marked epilepsy, which had existed six years, when she came under my observation, and which gave every indication that it would last throughout her life time. Gowers says that emotional shock is a cause of epilepsy in $5\frac{1}{2}\%$ of all cases. This percentage is higher than I have found it to be in my own experience, but all neurologists agree that emotional shock is not an infrequent cause. A large number of these cases could be prevented by a more careful and judicious management of nervous children.

Convulsions are very often produced by continued irritation to the peripheral nerves of any part of the body, and these so called reflex convulsions are liable to pass into genuine epilepsy in nervous individuals and in those predisposed to the disease. Good authorities have reported cases originating from such irritations as severe injury to the eyes, fracture of the nose, carious teeth, abscess of the ear, and injuries involving the nerve trunks. The irritation may be so trivial as to be overlooked unless carefully searched for. Such a case came into my hands, a few years ago.

An old man of sixty years or more had been having convulsions of an epileptiform type for several weeks. The first examination failed to reveal any other disease than the convulsions, and no cause was found for them. After he had been under observation for a number of days it was found that one of his teeth were loose and sensitive, and pressure upon this tooth would invariably produce a severe general convulsion. The tooth was extracted and he had no more fits. This man undoubtedly would have become an epileptic if the peripheral irritation had been allowed to continue for a sufficient length of time.

A careful and diligent search should be made in all cases of recently developed convulsions where there is the slightest suspicion of the existence of any peripheral irritation. If the source of the irritation is found and removed early, the symptoms usually abate, but if the condition is allowed to continue there is great danger of it passing into a genuine epilepsy which will often persist after the removal of the local irri-

tation. Time is an important factor in determining the course of such cases.

Of recent years, gastro-intestinal disorders have been given a prominent place in the etiology of all nervous diseases, including epilepsy. The usual derangement consists of indigestion due to over eating and improper diet combined with faulty elimination. The stomach is overloaded and and only a part of its contents can be digested. The remainder undergoes fermentative and putrefactive changes either in the stomach or in the intestinal tract, and, owing to a sluggish elimination, remains an irritating and toxic mass within the system. This probably acts both locally as an irritant to the peripheral nerves, and directly on the nerve centers by absorbed poison. Of these two actions the latter is, in my opinion, decidedly the major one. The exact nature of these toxins and the method of their action are as yet unknown, but any extended clinical study of epilepsy will convince one of their presence and potency. The initial seizure in a considerable number of cases occurs at night after a heavy supper, and the relatives of patients often bear witness to the fact that one or more seizures are apt to follow an unusually hearty meal. Indeed many epileptics themselves fully realize the bad effects which follow over-eating. The condition here points to the remedy. People should be impressed with the necessity and importance of being temperate in eating as well as in drinking. Gormandizing is as surely a species of intemperance as alcoholism and should be so considered. Constipation which is usually the result of habit and bad hygiene should be corrected.

Injury to the head has long been recognized as a cause of epilepsy. A small number of cases have resulted from injuries due to a faulty technique in instrumental deliveries, and some from falls in childhood, but the larger number of such cases are developed from injuries received in adult life. A considerable percentage of all cases of epilepsy acquired in adult life are traumatic in origin. A lesion over the motor areas of the brain is more apt to produce the disease, but it may result from an injury to any part of the head. Trauma as a cause of epilepsy is found much more often among males than females because of their greater exposure to accident. Most authorities give it as a cause in from three to five per cent of all cases. These figures are somewhat lower than those shown by my own cases. It is undoubtedly true that there are more cases of traumatic epilepsy in adult life now than formerly because of the increased use of machinery and the corresponding increase in accidents resulting therefrom. A great deal can be done to prevent the development of epilepsy in cases of head trauma by proper methods of treatment. In every case of fracture with depression the depressed bone should be thoroughly elevated so that all pressure upon the brain is entirely relieved. If pieces of bone are gone or are so comminuted or infected as to be unfit for use, the result

ing opening should be closed by the use of some other material. Platinum and celluloid are probably the best materials for that purpose, but several others have been recommended. In every case where it is necessary to do a simple trephine operation the disk of bone should be replaced or the opening closed by a plate. If such a course were always followed in the management of head injuries, the number of patients subsequently developing traumatic epilepsy would be very materially reduced. Without further discussion of the individual causes it must be quite apparent that much can be done both by the profession and the laity in the way of the prevention of epilepsy. As is always true in preventive medicine, success will depend largely upon the co-operation of the general public. This can be gained only by the dissemination of a better knowledge of the subject, and there is no one so well suited for the diffusion of this knowledge as the family physician in his capacity of medical consultant and confidential adviser. If he will take upon himself this public duty and teach the gospel of better hygiene and right living, and the proper care and management of nervous, unstable children, he will find that as regards epilepsy the proverbial "ounce of prevention" is worth many "pounds of cure."

SOME EYE LESIONS IMPORTANT TO THE GENERAL PRACTITIONER.*

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Many of the diseases that interest the oculist and that require his very best skill and judgment are of minor importance to the general practitioner. Either he sees them so seldom, or they require trained touch for their relief, or they are difficult of diagnosis, requiring familiarity with the ophthalmoscope, or they seem too trivial. At any rate he is not interested in them. On the contrary the majority of eye-cases seen by the oculist are first seen by the family physician. Many eye diseases are simply the local manifestations of a constitutional disease and have a practical bearing on the diagnosis, prognosis and treatment. For instance, a case of well marked albuminuric retinitis may be diagnosed before the attending physician has become aware of the kidney condition; it denotes that the patient will probably die within two years and it at once suggests treatment directed toward the kidney. Syphilis is another disease of similar kind. The eye frequently marking as specific a case that has puzzled the practitioner. Dealing as he does with

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the questions of suffering and death, most of his time being occupied with the problem of curing the diseases incident to his community; the physician has little time to devote to this, to him, minor branch of medicine. Between visits to patients and office calls he snatches time to keep himself well informed on the subjects of his every day work and even to do some literary reading. But when we think of the range of this work; that it covers most of the specialties: surgery, gynecology, obstetrics, diseases of children, diseases of the chest, heart and stomach, with a thorough knowledge of fevers and affections of the alimentary canal, we are astonished that he can so perfectly fit himself for so Herculean a task. The special study of the eye has been of so comparatively recent origin that the general practitioner has hardly adapted himself to its study, as yet, to the same comparative degree that he has devoted to the other well known specialties and while there has been some inclination to discourage him in this direction it is my purpose in this paper to advocate such a study.

Injuries to the eye occur in the most remote hamlet as well as in the crowded cities. The injured patient needs intelligent and discriminating care. His physician should know whether the wound is a serious one or not. If not he should be competent to dress it and care for it. If it, however, involves the deeper parts of the eye or needs for its care special instruments, such as he has not at hand, or demands delicate surgery such as is only acquired by long training of the eye and hand; he should be glad to relieve himself of the responsibility of handling the case and refer it to his nearest oculist of skill. Or if he is in doubt as to its gravity this should be done.

On April 26, 1906, I was called upon to dress a wound that affords a good example of this kind of cases. Mr. B., a machinist, while cutting a sheet of iron with a large pair of shears, was struck in the right eye by what he supposed was a piece of metal broken from the shears. A few minutes after the accident he presented himself at my office for treatment. An inspection of the injury revealed a vertical cut about half an inch long, at the junction of the inner and middle third of the lower eye-lid, and a quarter of an inch below the palpebral edge. Through this cut protruded a piece of tissue the size of the end of a lead pencil. A closer examination revealed the fact that the object had perforated the eye-lid and on superficial examination this was all of the injury, but on rolling the eye upward it could be seen that there was a perforation of the conjunctiva well down near the lower fornix. Into this opening I introduced a probe for five-eighths to three-fourths of an inch and felt around carefully avoiding further injury to the globe, but found no foreign body. The pupil was normal in size and reaction, through the upper part there was some red reflex, and the lower part was filled with a dark exudate, presumably blood. His vision in this eye was 20-100, there was no blood in the anterior chamber. The lower part of the conjunctiva was swollen and showed the small perforation spoken of before, which looked as though a shot had passed through it. The patient did not know whether a large piece of iron had struck him and fallen out, or a smaller piece had entered and remained. Not finding anything with the probe, I used the magnet, and at once got response. After four or five attempts, I succeeded in

withdrawing a piece of iron $\frac{3}{8}$ of an inch long, $\frac{1}{8}$ of an inch wide and 1-16 of an inch thick. Had this been left to wait for developments the patient would certainly have lost his eye. As it is he stands a good chance for recovery with a fair degree of vision.

Trachoma when seen in its earlier stages can usually be controlled and its serious sequelae prevented by judicious treatment. But when confounded with conjunctivitis or iritis or neglected entirely it becomes a formidable disease and a menace to the health of the community.

All localities are subject to cases of iritis and, once in a while, each community may have an outbreak of glaucoma. I believe the physician can learn to diagnose these diseases with much accuracy and it is only because his mind is filled with the constitutional side of disease that errors are so often made in these diseases.

There is a disease seldom recognized by the general practitioner that is of importance to him. It occurs usually in children and always denotes a lowered vitality, especially does it express a tendency to enlargement of the lymphatic glands of the neck and it calls for constitutional treatment in the way of oils and tonic alteratives with nutritious diet. I refer to phlethenular conjunctivitis.

Then there is blepharitis which is so often mistaken for trachoma, and chalazion so frequently diagnosed as sty.

I think I have enumerated enough common diseases simply as examples to show what my thought is; namely, the physician should make himself master of some good concisely written work on diseases of the eye and should keep such a book in his library for reference. He should be able to treat the simpler diseases, such as conjunctivitis and minor wounds, should be able to recognize with the ophthalmoscope, the grosser lesions of the fundus, such as marked cupping of the disc. He should not, however, feel that he is capable of handling all cases of diseases of the eye; for there are many of its diseases that are as difficult to learn as, and more difficult to treat than, many of the serious general diseases with which he comes in contact so much in his life work, and they require the seeing of many cases to become proficient in their care.

The Evergreen Place Hospital and Sanitarium was burned down on March 18. We extend to Dr. Goddard our condolences. He informs us that he is taking care of his patients at the Planters hotel in Leavenworth, but will have a new building on the old ground within ninety days. This building will be in the mission style and will be fire proof.

GONORRHEAL EYE LESIONS.*

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Gonorrhoeal affections of the eye are of equal interest to both the general practitioner and the specialist, as in the majority of cases the eye conditions are preceded or accompanied by gonorrhoeal urethritis. The gonorrhoeal affections of the eye manifest themselves as a conjunctivitis, iritis, or irido-choroiditis. In gonorrhoeal conjunctivitis three varieties are distinguished: Ophthalmia neonatorum, gonorrhoeal conjunctivitis in the adult, and toxic or metastatic conjunctivitis.

The term ophthalmia neonatorum is applied to the purulent conjunctivitis occurring in infants and is produced by the inoculation of the conjunctiva with the micrococcus gonorrhoeae of Neisser, either directly or indirectly from the discharge of the vaginal canal of a mother who is suffering from gonorrhoea. If there is any doubt as to the nature of the infection a careful microscopical examination should be made of the discharge. It is interesting to note that this condition is responsible for a large per cent. of the preventable blindness. Fox states that in the United States thirty per cent. of the blind have lost their sight as a direct result of ophthalmia neonatorum and its sequelae. Harmen, who has given this affection special study in England, states that 38.6-10 per cent. of the blind children in care of the London County Council owed their unfortunate condition to this disease. Thus it is evident that in this day of antiseptics this is a serious affection and should receive our most careful attention.

In infants both eyes are generally involved. I have never seen a case in which only one eye was affected; nevertheless, a few are reported. The affection presents itself under various degrees of intensity, usually there is intense injection of the eye ball, swelling of the lids, early a thin flocculent discharge often tinged with blood; this discharge, however, in a few days is followed by a profuse yellowish secretion which continues for some time, depending upon the severity of the infection and the care of the patient; as Pirringer has demonstrated that the more virulent the source of infection the more severe is the conjunctivitis which follows.

The cornea should be the object of our greatest concern, as the outcome of the patient depends largely upon the manner in which this

*Read by title before the Kansas Medical Society at its meeting in Topeka, May 7, 8 and 9, 1906.

important structure weathers the storm to which it is subjected. The cornea may remain clear throughout the entire attack. Its invasion will show either a diffuse haziness or a single spot of purulent infiltration or ulceration. This may occur in any part of the surface of the cornea; it may be only superficial, leaving a faint macula as sequela or may go on to perforation. If the perforation occur in the periphery the iris will probably fall upon the opening and become adherent. If near the center the lens will most likely come forward and rest in contact with the posterior surface of the cornea and is generally followed by a partial or complete opacity of the lens.

The prophylactic measures to be employed on the one hand are the treatment of the mother previous to parturition and the care of the infant's eyes after its birth. Before labor the vaginal canal should be carefully cleansed with some antiseptic solution and during labor the birth canal should be occasionally flushed in order to render the parts as aseptic as possible. Immediately after the delivery of the infant the outer surface of the lid should be cleansed with boracic acid or some mild antiseptic solution and a drop of a two per cent. silver nitrate solution applied between the lids of each eye. This should be applied as soon after birth as possible, as Runge has demonstrated that by waiting an hour the application will likely not be effective. This is known as Crede's method, who first put it into practice at the Liepsig Lying-in Hospital, and its value is shown by the fact that in this institution an average of ten per cent before the use of this method was reduced to one tenth of one per cent. I question the advisability of this routine in every case of labor, but if there is any doubt in the mind of the attending physician, then the above treatment should be carefully carried out.

In the beginning when the lids are swollen and the discharge is thin and watery the eyes should be frequently cleansed with some antiseptic solution. I generally use a solution of permanganate of potash, 1-5000 to 1-10000. Some prefer a bichloride solution. I doubt if it makes much difference what solution is used, as its efficacy does not depend so much upon its antiseptic as its cleansing properties. The eye should be flushed, whenever the secretion accumulates beneath the lids, from one to three times an hour. Great care should be observed during the cleansing process not to injure the surface of the cornea. I prefer to cleanse the eye by squeezing a pledget of cotton saturated with the solution. In this manner there is no danger of abrading the surface of the cornea as might be done by using a dropper or syringe, especially while in the hands of a parent or nurse. Between washings, if there is much swelling, iced pledgets should be applied to the lids; if the swelling and chemosis is not intense we can dispense with the ice and rely upon care-

ful cleansing. After a few days when the discharge becomes purulent and yellowish the swelling recedes and the lids can be everted. Begin the application of a two per cent. solution of silver nitrate applied to the everted lid once a day and continue the cleansing process.

The cornea must be carefully watched for any sign of invasion and when this occurs instil a drop of atropine solution several times a day and continue the previous treatment; if the ulcer threatens to perforate it will sometimes be well to do a careful paracentesis over the bulging point. This application to the lids should be continued until we get entirely rid of hypertrophy and secretion. This will take some time, generally three weeks or more.

Gonorrheal conjunctivitis is that form of purulent conjunctivitis occurring in the adult, the infective material being carried to the eye by the finger, infected towel or linen. The picture that these patients present is such that it is not difficult to recognize, but if there is any doubt about the diagnosis, microscopical examination should be made of the discharge. In fact, the laity is becoming educated in regard to this condition and not infrequently we are consulted by patients suffering from gonorrhea who imagine they have an infection of the eye when only some slight conjunctivitis is present. Its onset is rapid, the conjunctiva intensely congested, lids swollen, hot and painful; the condition presented is generally more severe than that which we see in infants, especially the swelling of the lids. Generally only one eye is involved. I have never seen a patient in whom both eyes were simultaneously affected. The discharge at first is thin, profuse and watery but soon becomes thick and yellowish; generally much chemosis; rarely this may be so severe that the lids become partially everted. In these severe cases of chemosis the danger to the cornea is great, as the cornea depends for its nutrition on the state of the vascular loops of the limbus. If there is much chemosis the lymph flow to and from the cornea is impeded, hence we find a stasis of the circulating fluid in the substantia propria. The normal resistance of the cornea is lessened and in addition the cornea is constantly bathed a pool of fluid loaded with micro-organisms, virulent and aggressive in nature. We can readily understand the danger to which it is subjected and the rapidity with which it sometimes breaks down. Fuchs expresses it: "The cornea seems in some cases to dissolve like ice in the sun." Fortunately, however, these very severe cases are not the rule.

The treatment in these cases requires a great deal of patience on the part of both patient and nurse. If only one eye is affected the other should be carefully protected. This can be practically done by placing a watch crystal over the good eye and holding it in place by strips of adhesive plaster. This permits the patient to use his good eye. This

glass can be removed, when necessary, for cleansing the eye of any secretion. The inflamed lids, as in the case of an infant, should be irrigated with some antiseptic solution whenever the secretion seems to accumulate between the lids. This may be three or four times an hour and in ordinary healthy patients iced pads should be applied almost constantly during the height of the attack if the cornea is not involved. This is objected to by some, but I believe it has a tendency to reduce the swelling, that it lessens the virulence of the infection and modifies the pain. Leeches, either natural or artificial, should be applied to the temple if there is much oedema and repeated as condition requires. In occasional severe cases an incision of the lid at the outer canthus will aid in reducing the oedema and lessening the pressure upon the eye-ball. After the secretion becomes thick and yellowish the swelling generally recedes. If the lids can be everted they should be carefully cleansed and once a day an application of silver nitrate applied, in two per cent. solution, and the careful cleansing continued. Much has been written and said in favor of the allied preparations of silver, particularly protargol and argyrol. In bad cases I have never relied upon them but have depended upon the nitrate solution. If the cornea becomes involved the ice application would better be stopped and heat used instead, the irrigation and silver application continued and a solution of atropine instilled into the eye several times a day. If the ulcer threatens to perforate it is considered by many better to anticipate the rupture and puncture the base of the ulcer. In some patients an ointment of yellow oxide of mercury applied to the lids after cleansing is of some benefit; it is gratifying to the patient at least, as in the case of infants the application of astringents and antiseptics must be continued until all secretions and hypertrophies, have been relieved.

Metastatic or toxic conjunctivitis is that form occurring in a person actually suffering from an attack of gonorrhoea, in which direct infection has not taken place but the conjunctivitis is due to a purely toxic condition of the patient. The gonorrhoeal poison has gained access into the circulation and excited inflammation in remote organs which have a predisposition for this poison. The inflammation is of a much milder type, resembling a severe catarrhal conjunctivitis, some little swelling and chemosis of the lids and eye-ball, very little if any pus, slight muco-purulent discharge, some lachrymosis, not much pain. No gonococci are found in the secretion. George, of Edinburgh, reports two such cases in which later the joints became involved. In connection with these cases it is of interest to note that Axenfeld was able to induce a similar condition into the conjunctival sac a dead culture of gonococci.

Five cases of irido-choroiditis were reported by Bull recently. The

onset of attack is sudden, accompanied by severe pain; impaired vision having a tendency to relapse, especially with renewed attacks of urethritis. These cases were associated with arthritis, which Bull maintains goes to show that gonorrhoea becomes a constitutional disease upon the occurrence of this affection. I have never seen a case, or at least never recognized either a toxic conjunctivitis or irido-choroiditis, but to speak of these conditions as possible complications.

Gonorrhoeal iritis is another complication that we see and is not so infrequent as some of the affections we have just mentioned. This affection may occur in those persons in whom gonorrhoea has given rise to general infection. All the authorities that I have been able to consult, if they mention this condition at all, state as a general rule that the joints are first involved, but that an iritis may occur and no joint complication be present. In this connection I desire to report two cases which show definitely this peculiar feature.

CASE I. Young man, age 19, never sick, family history negative, while working on a ranch last October contracted gonorrhoea; got some medicine at a drug store and treated himself. He showed no complications until a few days before I first saw him on March 3rd, but the discharge from the urethra had persisted; on March 3rd he stated that his left eye had been watering and paining him for several days; had kept him from sleeping well the previous night. The eye-ball was very much congested, the congestion being particularly intense in the pericorneal region; lid not much swollen, iris dull and reacted partially to light. Upon the installation of atropine solution at first the iris dilated irregularly, but after several hours the adhesions gave way, giving a round, dilated pupil; there was some exudate in the anterior chamber; vision blurred. We continued the introduction of the atropine solution and began the application of heat and referred the patient to his physician for examination and treatment of his gonorrhoea. He reported a chronic gonorrhoea with stricture of the urethra. For several days the exudate continued to increase, the cornea becoming cloudy and vision lowered to counting fingers at four or five feet. At the end of the first week's treatment he began to improve, the cornea cleared up, the exudate gradually decreased so that by the end of the third week the eye was practically well. About this time, March 31st, the patient began to complain of his left ankle joint being swollen and painful, and a few days later his knee became involved, but no other joint has been affected, but the knee is still sore. His eye is entirely well, vision 20-20, or normal. The peculiar character of this case is that only one eye was involved, the right never showing the least tendency to any complication, and that the iritis developed as the first indication of a general infection.

CASE II. Mrs. A.—, age 35, general and family history good, mother of several children, never has had rheumatism, innocently contracted a specific urethritis a few weeks before I saw her on March 19th. She was under the care of her family physician, who had warned her to be careful in regard to her eyes, and at the same time being attended by a skillful trained nurse, the first evidence of trouble in the eyes was at once recognized. Patient complained of lachrymation and photophobia and some pain in both eyes and temples, slight blurring of vision. There was a moderate pericorneal congestion iris slightly dull, pupil sluggish, but dilated upon the introduction of atropine, at first slightly irregular, but soon became round. In this case the congestion was never intense; vision was lowered some, but not to any extent. At the end of several weeks the

eye symptom disappeared and no other evidence of general infection has occurred. Atropine solution was instilled several times a day and moist heat most carefully applied by the nurse in attendance. The internal treatment was under the direction of the family physician.

In case 1 sodium salicylate was given and in case 2 methylene blue and some tonic was prescribed. In cases where there is much exudate potassium iodide or mercury might be given and a subconjunctival injection of salt solution is recommended by some.

In conclusion I wish to emphasize the fact that gonorrhoeal affections of the eye are serious conditions; that every patient suffering with a gonorrhoeal urethritis is predisposed to any of the above complications and the advisability of instructing patients in regard to the care and caution which they should take relative to the eyes, and the necessity for the attending physician to be on his guard and recognize at once any complication that may arise, as early, careful treatment of these cases is of vital importance.

THE INDICATIONS FOR THORACENTESIS IN THE TREATMENT OF PLEURISY WITH EFFUSION.

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About fifty years ago two physicians, Morrill Wyman, of Cambridge, Mass., and Henry I. Bowditch, of Boston, introduced aspiration in pleurisy with effusion, and made statements regarding the treatment of pleurisy which, according to most of our modern text books, represent the opinion of today. These observers practically ignored the factor of pulmonary tuberculosis in the etiology and course of pleuritic effusions. They did not recognize the possible curative effect of a pleuritic effusion in pneumonia, but advised the removal of fluid from the pleural cavity to prevent the development of a subsequent tuberculosis of the lung. In the light of our present knowledge of the varieties of pleurisy with effusion, it seems illogical to hold that they should all be treated in the same manner, or that aspiration should, or should not, be resorted to regardless of the type of the disease or the condition of the compressed thoracic contents.

Dr. E. N. Martin, of Benedict, Kansas, has in the March number of this JOURNAL, given us, in a brief and lucid manner, the advanced view regarding the treatment of the pleural complications of pneumonia. In this paper I shall discuss the varieties of serous pleuritis that are, as a rule, not directly associated with pneumonia, and of course, not within the scope of Dr. Martin's article.

The indications for thoracentesis in pleurisy with effusion depend upon the type of pleuritis that is present, the extent of the effusion, the severity of the pressure symptoms and the presence or absence of a tubercular involvement in the compressed lung.

Non-tubercular pleurisy with extensive effusion is uncommon. Kelsch, Vaillard, Eicchorst, DeLamany and others are of the opinion that a non-tubercular pleurisy that is sub-acute or chronic in character very rarely occurs. On the other hand, it is probable that non-tubercular pleurisy with effusion do occur, and may be of long duration. Dieulafoy, Netter, Debove, Achard and others are firm believers in the occurrence of a non-tubercular pleurisy with effusion. Although the majority of chronic pleurisy are tubercular, in all probability non-tubercular chronic forms do occur. In these cases aspiration should not be resorted to in the early stages of the disease, unless pressure symptoms demand it. If the disease has progressed for two or three weeks and the fluid shows no tendency to disappear, we should follow the advice of Kidd and resort to aspiration. If, during the course of these cases, the pressure symptoms seriously inconvenience the patient, aspiration should be done at once. If the fluid fill the pleural cavity, or extend as high as the second rib, it is usually wise to aspirate. The effusion should also be removed if it is so situated as to produce considerable displacement of the heart. There is no serious objection to resorting to aspiration in these cases.

Although most authorities are in accord with the foregoing, there are some who take exceptions to these statements. Nothnagel, of Vienna, and Nammack, in this country, strongly oppose aspiration in pleurisy with effusion, unless "it is absolutely demanded on account of asphyxia from pressure, or serious symptoms that can be explained by the mechanical presence of the fluid." On the other hand, Furbinger, of Berlin, insists that there is no danger attached to withdrawing pleural effusions, and advises that it should be done in all cases, even if the quantity of fluid be small and in no way discomfort the patient. These radical statements indicate that the problem of treating pleurisy is unsolved.

In the treatment of pleurisy with effusion it is of interest to know the procedures that have recommended and put into practice. Levaschoff and Tanfileiff have successfully replaced the effusion with normal salt solution. Kawahara recommends air lavage of the pleural cavity after paracentesis; and Bernard replaces the pleural effusion with gelatinized serum. Bernard especially recommends his method for cases of hemorrhagic pleurisy.

Tubercular pleuritis with effusion, without the presence of tubercular changes in the lungs, is not an uncommon occurrence. Eugene Hod-

enpyl, in a series of one hundred and thirty- one examinations on adults' found that tubercular involvement of the pleura, without tubercular disease of the lung, was of frequent occurrence. A tubercular pleuritis with effusion, without active tubercular change in the lungs should receive the same treatment, from the standpoint of aspiration, as the non-tubercular pleurisies.

A tubercular pleurisy, associated with active tubercular changes in the lungs, is very common. A majority of the chronic pleurisies with effusion are secondary to pulmonary tubercular changes. It is a much discussed question when aspiration should be employed in treating these cases, or whether it should be done at all. As a rule aspiration is advised in these cases if the effusion is large, or produces serious pressure symptoms. The advantage of leaving the effusion in place is that the compression of the lung is supposed to have a salutary effect on the tubercular process. Pulmonary compression with nitrogen, as advised and practiced by Murphy and others, in the treatment of pntthisis, accomplishes the same result as would a pleural effusion compressing the lung. Recent observations of M. DeCisternes and M. Sabourin, of Paris, go to show that pleurisy with effusion is of great benefit to the lung changes so commonly found in these patients. These observers report cases in detail, and discuss the rationale of the means of cure by the presence of the effusion. Their clinical experience, associated with observations of artificial pulmonary compression, shows that we should hesitate to remove the pleuritic effusion in cases of pulmonary tuberculosis, unless serious compression symptoms positively demand it. If the effusion produces no serious symptoms, there can be little harm in allowing it to remain. If its presence in any way contributes to a satisfactory termination of the pulmonary lesions, the fluid should not be withdrawn unless its presence threatens to terminate the life of the patient.

The Southwest Medical Associaton.-This society held its first meeting last October and it was decided to distribute the papers read in Oklahoma City among the various journals published in this territory. Thus far none has been "distributed" to us. While we do not in the least lack for material we hate to be left out entirely, because we believe that the "great state of Kansas" deserves better treatment. It seems to us (and it is a growing conviction) that the Southwest Medical Association is supernumary and while pleasant to attend not at all vital to the medical interests of Kansas.

ADDISON'S DISEASE.*

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This ailment is so rare that we seldom meet it, and one may practice medicine for years without seeing a single case. Therefore before relating to you some experiences that I have had with it I will first briefly outline the characteristics of the disease and give some of the salient points in its history.

This so-called Addison's disease is characterized by degeneration of the supra-renal capsules. The outward manifestations are a peculiar pigmentation of the skin, marked physical and mental asthenia, feeble circulation, and more or less irritability of the gastro-intestinal tract.

It is named in honor of Dr. Addison of Guy's Hospital, London, who first made an exhaustive study of its pathology, and in a monograph described its symptoms, morbid anatomy, and other characteristics, in 1844. It will be seen then that a knowledge of this disease is of comparatively recent date. Owing to the fact that it is of such rare occurrence it follows that still very little is known definitely concerning its etiology. In all cases they are found degenerative changes in the supra-renal capsules, but the character of these changes is not always the same. In a great majority of cases, tuberculosis seems to be directly connected with the disease, if indeed it be not the cause. But when this is the case, other organs suffer also from tuberculosis, and general tuberculosis usually contributes to the diseased condition. In some cases, however, no other symptoms of tuberculosis exist and it is difficult, if not impossible to demonstrate that it is of tubercular origin. Indeed in a few cases it has been found that the degenerative changes of the supra-renal capsules partake of the nature of carcinoma, sarcoma, or simple chronic inflammation. So while usually we may attribute this disease to a tubercular diathesis yet from the fact that tuberculosis does not always co-exist with it, we must conclude that it is not entirely dependent upon the tubercular bacillus for its cause, and have to content ourselves with saying that the etiology is obscure, and yet to be discovered and defined. Indeed from the fact that other portions of the anatomy aside from the supra-renal capsules are nearly if not always involved in the degenerative process it is a matter of doubt whether the condition of these glands is the cause or the result of the disease.

*Read before the Northeast District Society.

The symptoms of the disease are more easily defined, and while not always uniform, have general characteristics which are comparatively easily recognized. The most striking symptom is the peculiar pigmentation of the skin. This does not always occur until after the disease has made considerable progress as is shown by the weakened condition of the patient. This pigmentation comes on very gradually, and varies in degree of color as well as in the portions of the body affected. Sometimes the pigmentation is in well defined patches. Again there is slight discoloration of the entire surface of the skin. More commonly there are slightly outlined patches on the flexor surfaces of the arm, in the axilla, in the groin, about the waist, or any part of the body closely confined by the clothing. In some cases where the dark pigmentation is more general there exist sharply defined patches of leucoderma which make a marked contrast with the surrounding darkened skin. In the mouth, on the palate, gums, and inside the lips patches of a steel blue color are usually found.

Although the pigmentation may be the first sign to identify the disease, progressive bodily weakness has usually existed for some time before it is manifest, and becomes more and more marked as the disease advances. The heart's action becomes feeble and rapid, and the extremities become cold and at times numb; so much so that there may be almost complete paralysis of sensation in the feet and tips of the fingers from lack of circulation.

The digestion may not suffer early in the course of the disease but sooner or later the irritability of the digestive tract shows itself by frequent attacks of diarrhoea and vomiting. The latter may become persistent and extremely distressing to the patient. There is usually polyuria, associated with irritation of the bladder; but albumen as a rule is not present.

The course of the disease is very marked and characteristic, and while there may be at times an improvement, yet with the present knowledge of its medical treatment, it is almost always sooner or later fatal; its progress is slow and the patient may live for several years. However, after the digestive organs begin to fail, the patient runs down rapidly.

The treatment as laid down in the books consists merely in meeting the indications as they arise the best one can with the ordinary medicines, with little or no prospect of effecting a cure, but hoping to ameliorate the condition of the patient for a time, and possibly thus to prolong life. To that end we are advised to give strychnine, and other heart tonics to strengthen the enfeebled circulation; bismuth and salol to soothe the irritable digestive tract; and also to give our patient the ben-

efit of hygienic surroundings, easily digested and withal nourishing food. It is also very important that he should have complete rest from physical exertion, and in every way conserve his strength to assist him to withstand the ravages of the ever-increasing disease. More recently it has been found that the administration of the supra-renal capsule very decidedly benefits the sufferer and great things are hoped for in effecting a cure.

Within the past few years, three well marked cases of this disease have come under my immediate observation, and I wish to give you the benefit of my experience with them.

I. THE FIRST CASE, which we may call Mrs. A, was a young married woman about twenty-seven years old. Although she had been under my observation for several years, she was not, strictly speaking, under my special care until after the disease had made great progress. In her case the pigmentation came very gradually, so much so, that it would be impossible to say when it first came, but it was noticeable as a very dark complexion long before she acknowledged to herself or to any one else that she was sick, though she had always been a very weakly woman. When her case came under my care, she was extremely weak, very much emaciated, and was suffering from frequent and increasingly violent attacks of head ache. Persistent vomiting had existed for some time and was becoming worse, so that she was retaining but little nourishment. The pigmentation was so uniform over the face and exposed parts of the body as to appear not as a discoloration, but simply like a very dark complexion; however, upon examining the body, it was found that over the chest and thighs were portions of normal skin which on being compared with the pigmentation, brought it out in sharp contrast. Her family history was exceedingly unfavorable, both her parents having died when she was an infant of some form of tubercular disease; and at the time of her illness, others of her near relatives were suffering from the same, while she herself showed well-marked symptoms of beginning pulmonary tuberculosis.

She was given treatment to overcome the vomiting and generally supportive treatment. In addition to this she was given four doses of supra-renal extract, but without any apparent effect. After a very distressing illness she went into coma, and died.

II. THE NEXT CASE was Mr. P., a man about forty-two years old. When I was called to see him he told me that he had been sick for a year or more and that had no idea what was the matter with him. Though he had been for some time under the care of his family physician in the town where he resided, no satisfactory diagnosis had been made. He was very emaciated and appeared feeble, though he was able to get about, and had that day come from his home town to Leavenworth. As I looked at him I came hastily to the conclusion that here was a case of advanced tuberculosis; but on examination, to my surprise, I found the lungs perfectly healthy, neither was there any family history of tuberculosis. The pulse was very rapid and feeble and I put my ear over his heart, confidently expecting to hear a murmur, but there was none. The heart's action, except for weakness and rapidity, was normal. Urine analysis showed no abnormal constituents of the urine, and nothing out of the way except a rather high specific gravity as is nearly always found associated with wasting diseases. He said that his appetite was good and bowels regular, but close inquiry developed that he was rather "finicky" about his eating, and had frequent attacks of indigestion. His business was farming. His face seemed to be markedly tanned; as this is often the case with farmers, I at first gave it no attention, but on inquiry I found that he had done but

very little outdoor work for many months, and had been in the house the greater part of the time, therefore had not been exposed to the weather, and the discoloration could not be attributed to tan; moreover, investigation showed that the discoloration was not limited to face and neck as would be in the case of tan, but extended to other portions of the body covered by clothing. A peculiarity of his case was that there were patches of leucoderma, exceedingly white, on his neck, forehead, and back of the hands, which were in very sharp contrast with the surrounding pigmented skin. There were discolorations of the mucous membrane of the mouth, anemia was very pronounced and blood examination showed a marked deficiency of hemagoblin. His extremities were cold and clammy, although he was in a warm room, and he complained of numbness of the feet, particularly of the soles of the feet. I had no hesitation in deciding that this was a case of Addison's disease. I gave him heart tonics and iron in different forms, but chiefly decided upon the extracts of supra-renal capsules given in doses of from five to seven grains three times a day, an hour after meals. Under this treatment for a time he made very rapid progress. His circulation was stronger, the coldness of hands and feet nearly disappeared, and there was slight gain in weight, with very decided gain in bodily strength. Along with this, naturally his mental condition improved: whereas he had been nervous and despondent, he became hopeful and resumed control of his business affairs which he had nearly given up. After he had been under treatment for several months, he thought he was nearly well, and applied for a life insurance, and as I have recently learned, was examined and passed by a physician. During this time of improvement there was no diminution in the discoloration of the skin. It remained the same. He was evidently shrewd, for he took his insurance examination at nine o'clock at night. About this time he became careless about taking his medicine, and did not visit me often, and some little time after was brought to me in a very debilitated condition, suffering from an attack of acute indigestion. At this time, the debility and prostration was out of proportion to the intestinal disturbances; however, under treatment, he rallied rapidly and was again put on the treatment with the supra-renal extract somewhat increased, and was soon able to return to his home. I saw him only a few times after this, and he passed out from under my care within less than a year from the time I first saw him. A number of months after this I saw a notice in the paper that he had died in a hospital in Kansas City.

III. THE THIRD CASE was a lady about fifty-five years old, who was sent to me from Farinount by my friend, Dr. F. She had been under his care only a short time, and had previously been treated in New York City. She was a person of rather peculiar disposition, and evidently of roving habits, and consequently it was impossible to get anything definite as to the history of her case. However, it was plain that she had been in poor health for some time, the pigment of the skin was very well marked indeed, and was of a very decidedly characteristic bronze color. She had very feeble heart action without any lesion, and gave a history of frequent fainting spells. She complained of numbness of hands and feet. She had very little appetite and frequent attacks of indigestion. Her condition as to strength varied. At times she could get about fairly well, while at other times she could scarcely get in and out of bed without the assistance of a nurse. I at once put her on the treatment with supra-renal extract, also giving the usual heart stimulants, and hygienic treatment. Her improvement was very rapid, and contrary to my advice, she soon left the hospital, and took rooms down town, taking care of herself. She concluded that she did not need the medicine and stopped taking it, when she grew worse rapidly. When she came to me again I put her on treatment, and she began to improve. This occurred several times, in such definite sequence as to leave no doubt as to the effect on the case of the extract. After a time, she stopped coming

to me and I learned that she had left town. A few months afterwards I was informed that she had died suddenly of "heart failure" in an adjoining town.

In relating the second case I neglected to say that the family history was good, no history of tuberculosis being found.

Now it goes without saying, that this meagre experience is not sufficient for proving any definite facts regarding the efficiency of this treatment, but a few conclusions are at least indicated:

The suprarenal extract supplies something to the physical economy essential to the well-being of the patient, which is not supplied by nature during the progress of this disease. If, therefore, it is given before the disease has made great ravages, great benefit will be derived.

It does not, however, cure the disease, as is shown by the fact that the the patient's condition deteriorates at once when the medicine is withdrawn.

Little or no benefit is derived from this medicine when the disease is associated with, (not to say caused by) advanced tuberculosis. This would probably also be the case when the disease is caused by malignant growth, although I have had no experience in this class of cases.

Suprarenal extract, then, is of the greatest value in the treatment of this disease when uncomplicated. With it, we may hope to partially at least, restore our patients to comfort and strength, and prolong their lives, but in spite of this treatment, there will come a time when the disease will progress in spite of it, and the patient succumb. In this medicine we have a great aid for ameliorating the patient's condition, but a cure is yet to be found.

Criminal Malpractice.—A woman patient died recently under the treatment of a man who is a registered physician and conducts a so-called baby farm in Kansas City, west side. The circumstances were suspicious enough to call for a coroner's inquest. The pathologist of the state university found that delivery had been made with the forceps and so forcibly that the cervix was torn for an inch and a half above the fornix. Inside the uterus were masses of decidua swarming with bacteria. The gut had been literally burned through by irrigations of a strong solution of corrosive sublimate,—evidently given with hope of germicidal action! Of course no action can be instituted to de-license this man, but the shame of such ignorance and scrupulousness should stimulate us to (1) educate the public and to (2) prevent the entrance into our ranks of men like this one. Higher standards of education in both medicine and morality are needed.

Correspondence.

A PROBLEM IN ORGANIZATION.

Dear Doctor:-

Your note containing reminder of dues to be paid received. As my father and I are in partnership, occupy the same office etc., the extra copy of the American Medical Association Journal and the State JOURNAL is superfluous. Of course we would both like to hold membership in those organizations and would like to ask if we may do it as a firm?

I, of course do not know whether a similar case has been brought to your notice but if it has not no doubt you could get the information.

Thanking you in advance for your trouble, I am,

Yours fraternally,

L. L. Uhls, M. D.,

Pres. Kan. Med. Soc.,

Dear Doctor:-

I enclose a letter from _____ and hope that you may consider it worthy of your attention. The question of honorary membership in the A. M. A. is of no small importance. In our county there are three firms of father and son practicing in partnership with a common office. They will not send \$10.00 for two Journals of the A. M. A. We wish that one of them should pay his dues and get the Journal, and when both are members in good standing in the county and state societies, as all six in our county are, that both receive membership in the national society if one of them send his dues and takes the Journal that both may read.

The subject is not new, and if properly presented will receive due and favorable attention from the American Medical Association.

Please transmit this letter with one of your own to Editor Hoxie and request from him a suitable editorial, that the Journal of the American Medical Association, which exchanges with him, may have the subject officially presented.

Respectfully,

N. HAYES,

Secretary Nemaha County Medical Society.

Dr. G. H. Hoxie,

Rosedale, Kans.,

Dear Doctor:-

The problem brought up by Drs. Uhls and _____ is a difficult one to solve. There are many cases similar to the one referred to. One proposition that has been debated is to have two kinds of membership: One providing for the payment of \$5.00 and include The Journal, and the other providing for the payment of, say, \$1.00 or \$2.00, and not including The Journal.

Another proposition has also been considered, and that is that The Journal should be separate and distinct from the membership; that membership in the county society should carry with it membership in the national association, as it now does in the state society.

In any event, the change would be a radical one and I am candid enough to say that I do not know what is best to be done, although I have given considerable thought to the matter, and so have others.

Where there are two physicians in the same family, as in this case, and one want to attend the meeting of the A. M. A. one year and the other the next, the easiest and cheapest way would be for one to hold membership one year and the other the next, each resigning in favor of the other, or in favor of the one who wanted to attend the meeting.

Very truly yours

GEORGE H. SIMMONS.

THE WOLLGAST CASE.

To the Editor:

Having been very busy I have had to neglect your letter of inquiry, for which I have been most sorry, but will now endeavor to answer, for I feel that it is due the state society to know something about this as well as about many other cases. The man concerning whom you inquire was not a partner in the true sense of the word at all, as no partnership agreement was entered into but rather the doctor whom you have been led to believe to be the one who had indulged this spite work, took this man Wollgast into his office as an office and chore boy, and persuaded him to study medicine, which he did to the satisfaction of all concerned. So well satisfied was the doctor with the arrangement, and the progress the student was making that he sent him out on cases at different times and gradually worked him in to become quite an aid to him in his practice, but all the time expecting that as soon as he could to have him go to college and qualify himself for the active practice of medicine. This went on till the winter of 1899 and 1900, when he decided to go to college even though two months of the term had passed and it was nearing the holidays. Well, whatever arrangements were made, no one seems to know but when the term expired he came home and with a diploma, which had been secured in the same fraudulent manner, that secured him his certificate from the state board. About this time, or shortly after, for reasons that might be given, but are not necessary, these parties agreed to work apart, and in the meantime Wollgast decided to register, and in compliance with the plain requirements of the law, he had to fill out his affidavit which was to accompany the diploma, setting forth the time spent in study of medicine, having spent only a little over three months in college it was necessary in order to obtain a certificate, to make a false affidavit which he did. This he acknowledged, a copy of the acknowledgement I will send you as it appears in our daily paper at the time of the trial. The doctor (his employer) knew nothing of this affidavit or of the methods used to secure a certificate until some time after. Then he wrote to the secretary and was informed correctly concerning the matter. This did not cause him at that time to take up the matter against Wollgast, for he had no disposition to cause him grief and not until last spring when he was elected councilman and Wollgast appeared before the council and mayor and asked to be appointed city physician. Then of course the doctor knowing his preparation and at this time knowing the method employed by him in securing his registration, charged fraud and incompetency, which was denied. He was thereby forced to prove his assertions, being supported by the representative physicians of Coffeyville who petitioned the city council and mayor to set this man aside. All this resulted in charges being preferred and the trial, the details of which I gave you in my previous letter. The fact that the majority of physicians took up the matter is evidence

that it is not a personal fight. That sort of talk is made to mislead those who are ignorant of the facts. The members of the state society are not prejudiced and can look the facts squarely in the face and will be influenced by anything or anybody that smacks of corruption and graft. It is not to be wondered at that this man is desirous of holding the certificate after going thus far with this nefarious work of deception and I presume that most people would cling as tenaciously to it as he, all things being equal, but it does not seem that the whole responsibility rests with the board who have wilfully and maliciously decided to retain this man in practice, after being shown that the time of his preparation did not exceed three and one-half months and having a confession of perjury (to obtain a certificate) by the defendant at the time of his trial. It does seem to me that sufficient evidence of graft exists in this case to justify an investigation by the attorney general and see what can be done by the aid of stubborn facts.

Coffeyville, Kansas

C. H. FORTNER, M. D.

The newspaper clipping referred to above is as follows:

In view of the publications that have been made the past few days concerning the differences between the physicians of the city and Dr. Wollgast, parties interested have submitted the following statement:

Editor of the Record: I notice in your issue of Friday you printed the Kansas City Times report of the proceedings of the Kansas State Board of Registration and Examination, in the case of Dr. George F. R. Wollgast. The Kansas City Times report is so inaccurate that, in justice to the gentlemen who compose the board, and my connection with the case, I beg to be granted a little space for explanation.

The charge against the defendant in this case was that, in order to obtain a certificate of registration, he filed a false affidavit, and that the false statements therein were perjury under our laws, which is one of the causes for which such certificate of registration may be revoked.

The testimony submitted in support of this contention was so abundant and convincing that before it was all introduced the defendant personally requested that no further evidence be introduced on that line, as he would admit that he did not attend the University Medical college for three consecutive years, as alleged in his affidavit.

The members of the board assured me that testimony on that point was sufficient, but raised the question whether or not they were bound by law to take cognizance of the falsity of the statements contained in the affidavit, if in another paragraph of the law they were obliged to issue such certificate on presentation of the diploma of a reputable (?) medical college.

At this stage of the proceedings I asked to be allowed to present the law on the case, and that decision of the board be deferred until such time, which was unanimously agreed to. So much was this the point on which the result hinged that Dr. Lewis stated the proposition, and asked me to repeat it after him, that no mistake might rise.

Therefore, it is evident that the action of the board was not the result of insufficiency of evidence on any question of fact, but was based on a purely legal proposition.

Respectfully submitted,

PHILLIP H. CASS,

Attorney for Prosecution.

June 16, 1906.

The College Affidavit.

¹State of Kansas, County of Montgomery, ss.

George F. R. Wollgast, of Coffeyville, in the county of Montgomery, state of Kansas, hereby makes application for a state license to practice medicine in the state of Kansas,

based upon diploma, and being duly sworn, deposes and says that he attended three full courses of medical instruction, as follows to wit:

At University Medical college at Kansas City, Mo., from the 10th day of September, 1897, to the 20th day of March, 1898.

At University Medical college, Kansas City, Mo., from the 9th day of September, 1898, to the 20th day of March, 1899.

At University Medical college, Kansas City, Mo., from the 9th day of September, 1899, to the 22nd day of March, 1900.

That he was granted a diploma as a doctor of medicine by University Medical college, located at Kansas City, state of Kansas, on the 22nd day of March, 1900, and that he is the identical person to whom said diploma was originally granted, and that the diploma presented is the genuine diploma of said institution.

GEORGE F. R. WOLLGAST.

Subscribed and sworn to before me, this 19th day of August, 1901.

MAURICE V. PERKINS,

Notary Public.

My commission expires on the 12th day of February, 1905.

State of Kansas, Cloud county, ss.

I, Taylor E. Raines, secretary of the Kansas State Board of Medical Registration and Examination, hereby certify that the above and foregoing copy marked "A" is full, true and correct copy of the original application of George T. R. Wollgast for a state license to practice medicine in the state of Kansas, now in my custody and possession.

In witness whereof I have hereunto set my hand and affixed my official seal, this 14th day of May, A. D., 1906.

(Seal)

T. E. RAINES.

Secretary of the Kansas State Board of Medical Registration and Examination.

A SQUARE DEAL.

To the Editor:

In the October issue of the Kansas Medical Journal appeared an article of unusual interest. While being absolutely valueless to the profession of the state or county from which it was sent on account of its wide variance from the facts in the case, yet interesting on account of the very exceptional character and the professional value of one of the parties named; the one to whom the communication was directed and whose ethical standing and principles it attempted to besmirch. As ex-secretary and treasurer of the Wilson County Medical Society, having served in that capacity for two years just past, I desire to correct the wrong impression the above named article created. I am in a position to know that the doctor referred to, knew absolutely nothing of the quoted article published in the local paper until it appeared in print, because I have in my possession a sworn affidavit to that effect. More than that I know who gave the interview, and I will say that the party who saw the reporter and gave out the facts in the case was not a member of the County Medical Society. No doubt the doctor could have written an infinitely better "Ad" for the paper had he chosen to stoop so low as to use the secular press for advertising purposes. And if I were allowed to comment on the surgical operation referred to I would say that it showed rare skill, both in technique and post operative care, also that the doctor is to be congratulated upon possessing this accomplishment rather than to have his ethics, integrity and honesty called into question. In the same number of the Journal in the same article

the author takes opportunity to place much of the blame on the Secretary for the promiscuous newspaper "write ups". The facts are the Society did not instruct the Secretary to write circular letters to the local papers but did instruct him to send copies of the resolutions to all the editors in the county. This the Secretary did do, and if our critic could confine himself to facts at least a part of the time the matter might be passed over, but such flagrant violation of the common rules of justice seems to need correction. I believe in the square deal, and so long as I am a member of the county society I propose to fight this continual "scrapping over nothing." Our society in the past has been rent asunder by reveling of evil minds, and it is high time to "cut it out." and foster a spirit of gentlemanly and professional treatment. We buried the hatchet some time ago, but once in a while some one goes out and weeps over the remains, has a bad dream, and off he goes with a chip on his shoulder. We have a good and well attended county society, and its splendid work and progress should not be impeded by small things.

E. N. MARTIN.

Turnip-top Treatment of Chronic Diarrhoea and Dysentery. C. Wilson and H. E. Pressly, Birmingham, Ala., *Journal A. M. A.* March 9, report six cases, four of chronic diarrhoea and two of amebic dysentery, microscopically diagnosed which were successfully treated with a diet of "greens" composed of turnip-tops. One of these patients, on going where the diet was not to be had, suffered a relapse and died, the other continued well. Other vegetables, such as mustard, phytolacca and spinach, are also mentioned as having been used to some extent. The attention of the authors was first called to the remedy by the recovery of an apparently hopeless case on "poke salid" (phytolacca) after leaving their care. Of the two cases of amebic dysentery, one patient had tried all the ordinary remedies, and was ready to undergo an appendicostomy or an enterostomy if it would relieve him, as his condition was extreme. The other was not so bad, but had given up his work and never expected to be able to take it up. Both made good recoveries under the "turnip-greens" diet. Wilson and Pressly have also tried it in two cases of well defined gastric ulcer, in one successfully. The other patient was nearly moribund, and while he was able to take the diet better than anything else, it failed to save him. The method of cooking is important, as it is very unpalatable if not properly prepared. As prepared as a domestic dish in the south, ordinary bacon is used, boiled half an hour, and the the turnip tops, spinach, mustard or phytolacca tops are added and allowed to boil for one or two hours.

Book Reviews.

Diseases of the Lungs by ROBERT H. BABCOCK, M. D., Chicago, with twelve colored plates and 104 text illustrations. First edition; cloth, 8 vo; pp. 809, New York, 1907, D. APPLETON & Co., PUBLISHERS.

This is the companion volume to Babcock's diseases of the heart. The author has spent three years in its preparation. Naturally, therefore, it is probably the most exhaustive monograph on the lungs by an American author.

Its Americanism shows itself in the catholicity of its viewpoint. The work of French, German, British, and other authors seems to have been studied and collated in the preparation of the volume. We find, therefore, a freedom from a dogmatism and a conservatism that gains our confidence.

In the discussion of the treatment of tuberculosis Wright's work is merely mentioned, but Trudeau's vaccination experiments are quite fully studied. Of course we should have been glad to see a fuller account of Wright's work and his methods of studying the opsonic index,—but inasmuch as such work as only in the experimental stage, it should hardly be given great space in a standard text.

On the whole Babcock's book is a distinct contribution to our medical literature and should excite emulation on the part of authors in related fields.

Greene Medical Diagnosis. A manual for students and practitioners. By CHAS. LYMAN GREENE, M. D., of St. Paul, Professor of the Theory and Practice of Medicine in the University of Minnesota; Ex-President of the National Association of Life Insurance Examining Surgeons, etc. With seven colored plates and 230 other illustrations, many being colored, 12mo pp., 683, Full Limp Morocco, Gilt Edges, Round Corners. \$3.50. Philadelphia: P. Blakiston's Son & Co.

The text is arranged especially as a reference book for students and general practitioners. Thus there are side indices, complete paragraphing, and a great variety of type.

Dr. Greene has evidently tried to condense his work to the limit. Therefore, we find many unclear and unhappy statements, which will doubtless be corrected in future editions. The information conveyed is certainly encyclopediac, and the book will prove very helpful to the puzzled student in his clinical work. However, it cannot take the place for initial study of more elaborate treatises on the various subjects discussed.

A Text Book upon the Pathogenic Bacteria. For students of medicine and physicians, by JOSEPH MCFARLAND, M. D., Professor of Pathology and Bacteriology in the Medico-Chirurgical College, Philadelphia. New Fifth Edition. Octavo volume of 647 pp, fully illustrated, a number in colors. Philadelphia. W. B. SAUNDERS COMPANY, 1906. Cloth, \$3.50 net.

Professor McFarland has succeeded in siezing upon the scholastic standpoint and therefore offers us a text of perennial interest,—of interest even when we know perfectly well the facts rehearsed. Everything is put into its proper historical setting. This insures a truer perspective than when an author seeks to assume the philosophical standpoint and develop an *a priori* hypothesis. For these reasons we believe that the very careful revision now before us will put Dr. McFarland's text even more firmly upon its pedestal as the leading American textbook of bacteriology.

A Text-Book of Pathology, ALFRED STENGEL, M. D., Professor of Clinical Medicine in the University of Pennsylvania. Fifth Revised Edition. Octavo of 977 pages, with 399 text illustrations, many in colors, seven full-page colored plates. Philadelphia. W. B. SAUNDERS COMPANY, 1906. Cloth, \$5.00 net, half Morocco, \$6.00 net.

To delineate clearly the anatomical basis for disease requires rare objectivity on the part of the writer and to be thoroughly successful requires also readers whose mental processes are active enough to grasp from the printed page an imaginative picture of the condition represented. To go further and present enough of pathological physiology to enable the the reader to comprehend the causation and development of the lesions is still more difficult. Professor Stengel seems to have attempted both of these feats in his textbook; and that he has satisfied his circle of readers is attested by the rapidity with which his publishers must issue new editions.

We do not say that this is our ideal of a text book in pathology. We think that Dr. Stengel is rather too subjective to be satisfactory to the advanced student and research worker. His book will probably not endure two decades, yet it is excellent for the beginner in affording him broad outlines and theories on which his future studies may be based. It is then as a school text that this volume finds its place.

Thornton's Pocket Medical Formulary. New Eighth Edition, revised to accord with the new U. S. Pharmacopoeia. Containing about 2,000 prescriptions with indications for their use. In one leather bound volume. Price, \$1.50 net. LEA BROTHERS & COMPANY, PUBLISHERS, Philadelphia and New York, 1907.

Everyone of us is subject to lapses of memory and we forget dosages, incompatibilities, etc., for drugs not in our every day practice. Thornton's pocketbook has, therefore, a right to exist. We only wish that the binding were of better leather, the paper thinner and the size

a little smaller. At the price charged the publishers could well afford to make these improvements. It is a book for the busy practitioner to carry in his pocket or his satchel,—and should be built, therefore, on beautiful and durable lines.

Text-Book of Psychiatry—A Psychological Study of Insanity for Practitioners and Students. DR. E. MENDEL, A. O. Professor in the University of Berlin. Authorized Translation. Edited and enlarged by Wm. C. Krauss, M. D., Buffalo, N. Y., President of Board of Managers Buffalo State Hospital for Insane; Medical Superintendent Providence Retreat for Insane; Neurologist to Buffalo General, Erie County, German, Emergency Hospitals, etc.; Member of the American Neurological Association. 311 pages. Crown Octavo. Extra Cloth, \$2.00 net. F. A. DAVIS COMPANY, PUBLISHERS, 1914-16 Cherry Street, Philadelphia, Pa.

Psychiatry is one of the departments of medicine which have only just begun to feel the impetus of modern scientific thought. Begun in Paris a little over one hundred years ago the humane treatment of the insane has gradually spread throughout the civilized world. The scientific treatment of the insane, however did not begin until Kraepelin and his school demonstrated that the laws of pathology were applicable to mental conditions as well as physical. What little we know today about the pathological anatomy of insanity, is due to Kraepelin and his pupils. Therefore it is easily intelligible that the English speaking countries are only just beginning to react on the stimulus to greater discoveries in the study of insanity. As Dr. Kuhn stated recently we have been regarding insanity as a hopeless condition, the causation and physiology of which was unknown and unknowable. Heretofore we have spent our time in securing for these people as humane and kindly care as possible.

Now, however, that psychiatry is being made a special department of the better medical schools and that "university clinics" for the insane are being established, there is a rattling among the dry bones. We hope that this rattle is premonitory of life. Here in Kansas we have an excellent opportunity to do great things, if the profession will only realize it. What we need is a greater opportunity for training our medical students in psychiatry, in order that as practitioners they may recognize insanity in its infancy, and institute proper treatment before it is forever too late. Too long we have bowed down to a knowledge of insanity that has been of the Wiley type. This opportunity for training medical students can be had only by establishing at a convenient center a receiving hospital, to which medical students shall have access, and in which regular internships shall be offered to recent graduates. We have already a few earnest workers in our institutions; they need our encouragement and support.

A proof of the growing interest in psychiatry is afforded by the appearance of a new book. Our choice of books written from the modern standpoint has been confined to Church and Peterson, a poor version of Kraepelin's tests, a translation of de Fursac, and some brief manuals. These have not proven entirely satisfactory, largely because no one of them has been written by an American working under American conditions, and yet equipped with a hospital where adequate studies could be carried on (as Osler had internal medicine for the production of his Practice.)

The book before us is very brief, and would be an excellent text for summarizing a tri-weekly clinic in psychiatry. But for the student shut out from such a clinic we fear the book will hold little of superiority to the already existing texts. Even for the practitioner who has not some clinical experience the very terseness (which renders the book valuable for reference) will prove a stumbling block, we fear. But for the man who knows something of mental disease and who wishes to refresh his memory, this translation of Mendel's text will be worth purchasing.

The Practitioner's Medical Dictionary. An illustrated dictionary of medicine and allied subjects, including all the words and phrases generally used in medicine, with their proper pronunciation, derivation and definition. GEORGE M. GOULD, A. M., M. D., author of "An Illustrated Dictionary of Medicine, Biology and Allied Sciences," "The Student's Medical Dictionary," "30,000 Medical Words Pronounced and Defined," "Biographic Clinics," "The Meaning and Method of Life," "Borderland Studies," etc., Editor of "American Medicine." With 388 Illustrations. Octavo; xvi. 1043 pages. Flexible Leather, Gilt Edges, Rounded Corners, \$5.00; with thumb index \$6.00 net. P. BLAKISTON'S SON & COMPANY, PUBLISHERS, 1012 Walnut St., Philadelphia.

The erudition of the author and the energy of the publishers in putting the work into such an attractive and usable form commends the work to our favorable consideration. We are not disappointed when we look into the book because it is conservative and correct. The Basle anatomical nomenclature has been adopted, thus bringing the book to date.

An Epitome of Diseases of the Nose and Throat. J. B. FERGUSON, M. D., of the New York Post Graduate Medical School. 12mo, 243 pages, with 114 engravings. Cloth, \$1.00 net. LEA BROTHERS & COMPANY, PUBLISHERS, Philadelphia and New York, 1907. (Lea's Series of Medical Epitomes, Edited by VICTOR C. PEDERSEN, M. D., New York.)

The author has presented in concise and practical form the diagnosis and treatment of diseases of the throat and nose. He has planned the book to be helpful to the under-graduate and post-graduate medical student in gaining familiarity with laryngological work, and likewise to the general practitioner, who is often called upon to treat diseases of this

region, and who needs to have the chief points in diagnosis and treatment concisely placed at his command. All these classes of readers will appreciate the systematic arrangement, the clear directions for examination, the illustrations of preferable instruments and of diseases, and the abundant formulae for the best medication. The Medical Epitome Series, of which this is the latest volume, will cover the whole range of medicine, surgery and the specialties in original books written by recognized authorities, and uniformly priced at one dollar.

Practical Diebetics, With reference to diet in disease, ALIDA FRANCES PATTEE, special lecturer in several New York City hospitals. Cloth, 12mo, 312 pages, (with 48 pages of advertisements.) Fourth Edition, published by A. F. PATTEE, Mount Vernon, New York. Price \$1.50.

This is a very practical little work,—a good cook book for nurses. Since the details of a receipt are matters of personal opinion, we need not take them up here. Our medical men do not know enough about individual preparations,—they content themselves, as does a friend of the writer, with a wave of the hand and the order, “Oh, give some kind of slop,” when a liquid diet is indicated. Hence a little reading in such a book as this would be decidedly helpful.

Text-Book of Alkaloidal Therapeutics, W. F. WAUGH, M. D., and W. C. ABBOTT, M. D. Second Edition. THE CLINICAL PUBLISHING COMPANY, Chicago, Ill. 8vo, 473 pages. Cloth, \$2.50.

Those interested in the “Alkaloidal Idea” will find this book a complete guide to all that has heretofore been published along that line as it contains the essence of all the articles which have appeared from time to time in the Journals and books of the country and Europe, pertaining to the subject. And to this is added the experience of the authors.

The reading matter is so arranged that each drug is taken up alphabetically, giving its standard granules, physiological actions, and therapeutical indications in detail. And for the physician’s convenience the book is interleaved with blank pages so that he may keep a note of the results obtained with each remedy.

While the name suggests that it treats only of the alkaloids, it deals with the concentrations, glucosides, resinoids, and many of the metallic drugs and salts in daily use. The greater part of this information has been obtained through articles contributed to “The American Journal of Clinical Medicine,” (formerly the Alkaloidal Clinic.)

Even for those who condemn the “Alkaloidal Way” the book is at least worth considering,—even a place on their shelves.—C. M. S.

Society News.

The Shawnee County Medical Society met at the National Hotel March 4th, 1907, and had the following program:

Dr. O. P. Davis—The interpretation of laboratory findings.

The discussion was opened by Dr. W. D. Storrs. Cases were reported by Doctors C. W. Schwartz and J. E. Bennett.

At our last meeting Dr. C. F. Meninger was elected to membership with the agreement that he be elected to membership on the condition that he resign from all his homeopathic societies.

The J. A. M. A. Editor sustained the decision of our society in regard to demanding that Dr. Meninger resign from the homeopathic societies before being eligible to our society.

Dr. H. S. Judd, of Lead, South Dakota, is going to locate in Topeka with Dr. Corban E. Judd, his brother, who is now on an extended vacation.

CORBAN E. JUDD,
Secretary.

Franklin County Medical Society.—PROGRAM—1907.

- Feb. 27—Pneumonia.....Jas. Ball
 March 27—Aconitum napellus and Veratrum Viride.....W. H. Gilley
 April 26—Mercury, Opium, Chloroform.....W. L. Jacobus
 May 29—Parasitic diseases of the skin and their treatment...J. R. Lytle
 June 26—Vaso-motor disturbances in disease; how manifested
 and how treated.....H. B. Johnson
 July 31—Eighteenth century medical practice compared
 with twentieth (historical.).....H. W. Wright
 August 28—Pyosalpinx.....R. S. Black
 Sept. 25—Lumbago and painful disease of muscles.....A. Haggart
 Oct. 30—Surgical bacteriology.....E. B. Gossett
 Nov. 27—Chronic duodenitis, diagnosis and treatment....C. W. Hardy
 Dec. 25—Cancer.....J. M. McWhorf
 Jan. 08—Influence of the mind over the body in health and
 disease.....H. P. Monroe

APPENDIX.—(Not Vermiform)

- The etiological factor in puerperal eclampsia.....V. E. Lawrence
 The physiological action and therapeutic uses of wood dis-
 tillates.....G. W. Davis
 The physiognomy, decubitis and voice in disease.....F. C. Herr

OFFICERS

W. H. GILLEY, President. C. W. HARDY, Vice President. H. W. WRIGHT, Secretary.

PROGRAM COMMITTEE.

F. C. HERR, V. E. LAWRENCE, G. W. DAVIS.

MEMBERSHIP.

R. S. Black	C. W. Ewing	F. C. Herr	H. P. Monroe
W. L. Birney	M. L. Foster	H. B. Johnson	J. M. McWharf
James Ball	J. A. Fuller	G. K. Janes	W. F. Nienstedt
J. Davis	E. B. Gossett	W. L. Jacobus	E. T. Pendleton
G. W. Davis	H. W. Gilley	H. L. Kennedy	L. W. Roller
J. B. Davis	A. Haggart	V. E. Lawrence	J. R. Thornbury
W. M. Ewing	C. W. Hardy	J. R. Lytle	H. W. Wright
Josephyne Eshom-Davis			

Papers for the Meeting of the Kansas Medical Society at Kansas City. May 7 to 10.

Address of Welcome, G. M. Gray, Kansas City.

President's address, L. L. Uhls, Osawatomie.

"Puerperal sepsis," G. A. Biddle, Emporia.

"Serious fracture of the skull," J. E. Oldham, Wichita.

"Metritis," J. E. Oldham, Wichita.

"Scarlet fever," G. M. Anderson, Beverly.

"Neuritis," W. A. Hulen, Lincoln.

"The Sunflower," J. M. Winegar, Hamilton.

"Senility," L. O. Nordstrom, Salina.

"Our professional standing," J. R. Scott, Independence.

"Scientific therapeutics," J. A. Connor, Burlingame.

"The use and abuse of normal salt solutions," F. A. Carmichael, Goodland.

"The conservative treatment of diseases of women with special reference to retrodeviations," Frances A. Harper, Pittsburg.

"Medical science," T. A. Stevens, Caney.

"Abortion," H. H. Brookhart, Scammon.

"Nourishment in disease," A. J. Roberts, Ft. Scott.

"Cold air bath and treatment of pneumonia," H. E. Davies, Emporia.

"Cough," W. F. Sawhill, Concordia.

"A report of a case of glioma of the olfactory bulb with demonstration of specimen," M. L. Perry, Parsons.

"Plastic gynecology," N. C. Speer, Osawatomie.

"Injuries to the intraabdominal viscera, due to blows, kicks, crushes and like accident," E. E. Liggett, Oswega.

"Surgery of the ethmoidal sinus," J. E. Sawtell, Kansas City.

"Nail injuries to the eye," J. W. May, Kansas City.

"Some lesions of the motor tracts of the cerebrum," C. C. Goddard.

'Septic peritonitis acute, diffuse," C. E. Bowers, Wichita.

"Three cases of tetanus, one case of hydrophobia, one case of priapism," A. J. Best, Centralia.

"The present and comparative state physically of the American people," R. A. Light, Chanute.

"Nystagmus," John S. Wever, Kansas City, Mo.

'Medicine as she is taught', O. P. Davis, Topeka.

"Vital statistics," Dr. Wilbur, Washington,.

"How can the local profession increase its usefulness and broaden its influence," G. W. Jones, Lawrence.

(Paper) S. S. Glasscock, Kansas City.

(Paper) S. E. Smith, Grantville.

(Paper) J. A. Milligan, Garnett.

(Paper) M. F. Jarrett, Ft. Scott.

(Paper) H. L. Alkire, Topeka.

(Paper) R. C. Lowdermilk, Galena.

(Paper) A. E. Hertzler, Halstead.

"The symptomatology of renal colic," W. F. Grove, Eureka.

NOTES.

A RECEPTION will be given at the Union club rooms, Seventh and Minnesota Ave. Kansas City, on Tuesday evening, May 7, at 8 o'clock. There we shall listen to Dr. Gray's address of welcome, and to Dr. Uhls' presidential address and have a chance to get acquainted.

A TROLLEY CAR RIDE will be tendered the society on Wednesday afternoon, May 8, at 4 o'clock. This ride will land the members at the Rosedale quarters of the university of Kansas, where refreshments will be served and the evening session held.

A BANQUET will be given the Society on Thursday night to which the ladies as well as gentlemen are invited. The Wyandotte County Society will present cickets to all the members of the Society in attendance at the meeting. Should the members desire to bring their friends, they may purchase the extra tickets of the, committee as late as Wednesday night. At this banquet we expect to have some of the best speakers in the state.

THE HOTEL HEADQUARTERS will be the Midland, corner of Seventh and Walnut streets. This is reached by the Union depot cars direct.

THE MEETING PLACE is in the club rooms of the Union club at Seventh and Minnesota Avenue. This is reached by the viaduct cars on Main street if one is coming from the Midland hotel. From the Union depot one should take the Chelsea Park or Quindaro Blvd cars west and transfer south at Sixth and Minnesota avenue.

HOSPITALS. Bethany Hospital is at Orchard and Tenney streets; St. Margaret's is at Vermont and Garfield, about one mile from the meeting place. Both these are on the west side. St. Joseph's is at Seventh and Pennsylvania, on the east side. The German is at Twenty-fifth and Holmes. The new City Hospital is just back of it. The Eleanor Taylor Bell Memorial Hospital is at College and Broad streets, Rosedale. Dr. Glasscock's Grandview Sanitarium can be reached by the Grandview car line, which runs within a block of the Midland. The Douglas Hospital (colored) can be reached by the Wyandotte cars, on Fifth street, west side.

List of Members in Good Standing in the Kansas Medical Society January 1, 1907.

Allen County.

J. S. Bass.....Iola	G. W. Longenecker .. Ellsmore
S. A. Coffman.....Iola	F. H. Martin .....Iola
W. H. McDowell.....Iola	P. S. Mitchell.....Iola
O. L. Garlinghouse ..Iola	G. W. Moore.....Iola
J. H. Hindman .....Humboldt	C. W. Renick .....Gas City
W. R. Heylman .....Iola	L. Tozer.....Iola
J. E. Jewell .....Moran	Edith S. Haigh.....Iola

Anderson County.

G. A. Blasdel.....Garnett	E. T. Metcalf.....Colony
W. M. Caton.....Colony	J. C. Smith.....Greely
M. E. Cunningham.. Garnett.	C. L. Simmons.....Westphalia
T. A. Hood.....Garnett	A. H. Skillman.....Mont Ida
J. B. Jones.....Garnett	D. O. Taylor.....Greely
J. A. Milligan.....Garnett	

Atchison County.

J. P. Blunk.....Atchison	C. H. Linley.....Atchison
D. W. Campbell.....Atchison	C. A. Lilly.....Atchison
A. B. Chase.....Atchison	J. F. Preston.....Effingham
J. C. Cole.....Huron	E. M. Pitts.....Atchison
A. L. Charles.....Lancaster	E. T. Shelly.....Atchison
W. F. Dingess.....Atchison	E. S. Moore.....Effingham
C. S. Ferguson.....Atchison	Lydia Stockwell.....Effingham
H. Linley.....Atchison	

Brown County.

J. J. Comes.....Willis	G. C. McKnight....Hiawatha
H. J. Deever.....Fairview	A. McGauhey.....Robinson
A. C. Davis.....Hamlin	W. W. Nye.....Hiawatha
F. Dunlap.....Horton	L. Reynolds.....Horton
F. H. Erwin.....Morrill	C. C. Stevens, Sr.... "
J. M. Eisenbise.....Fairview	C. C. Stevens, Jr.... "
R. L. Funk.....Powhattan	R. Stewart .....Powhattan
G. S. Graham.....Fairview	L. W. Shannon.....Hiawatha
S. T. Gillispie.....Reserve	V. C. VanVoorhis....Robinson
S. J. Herrick.....Everest	J. O. Ward .....Horton
J. D. Horn.....Horton	

Butler County.

N. O. Bennett	Eldorado	J. R. McCluggage . . .	Douglas
J. B. Carlile	Edwards	C. H. McMillin	Leon
F. E. Dillenbeck	Eldorado	Anna Perkins	Eldorado
J. D. Hamilton	Douglas	D. C. Stahlman	Potwin
C. E. Hunt	Eldorado	P. B. Smith	Augusta
J. S. Kline	"		

Barton County.

Ed. Atkins	Olmitz	O. P. McPherson	Great Bend
A. H. Connett	Great Bend	S. S. Meyer	Hoisington
M. L. Daniels	Pawnee Rock	E. E. Morrison	Great Bend
P. L. Howe	Olmitz	R. H. Meade	Great Bend
A. R. Haas	Ellinwood	J. H. Morgan	Dighton
H. W. Jury	Claffin	G. O. Speirs	Ellinwood
C. C. Koons	Larned		

Bourbon County.

J. B. Carver	Fort Scott	W. S. McDonald	Ft. Scott
W. L. Hopper	"	J. R. Nusman	"
S. C. Hall	"	E. B. Payne	"
R. R. Hunter	Fulton	C. A. Van Velzer	"
M. F. Jarrett	Fort Scott	A. J. Wood	Fulton
W. S. Metta	Uniontown		

Cherokee County.

J. H. Boswell	Baxter Springs	R. C. Lowdermilk	Galena
F. L. Ball	Hallowell	R. S. Mahan	Mineral
J. H. Buckles	Mineral	H. P. Mahan	Parsons
G. P. Bell	Mineral	G. B. McClellan	Weir
L. W. Baxter	Columbus	R. M. Markham	Scammon
J. H. Boss	Weir City	F. D. Northrup	Galena
H. H. Brookhart	Scammon	W. R. Scott	Columbus
R. B. English	Baxter Springs	A. A. Shelly	Galena
J. D. Graham	Artesia, N. M.	J. P. Scoles	Galena
J. H. Green	Galena	H. B. Savage	Galena
A. R. Holmes	—	R. C. Wear	Baxter Springs
C. S. Huffman	Columbus	G. W. Walker	Melrose
W. N. Johnson	Columbus	A. T. Revell	Scammon
C. H. Jones	Galena	P. J. Hendrickson	Columbus

Cloud County.

J. H. Brierly	Glasco	S. C. Pigman	Concordia
Chas. Caton	Concordia	W. R. Priest	Concordia
G. W. Coffey	Concordia	W. F. Sawhill	Concordia
G. N. Hartwell	Jamestown	A. G. Sexton	Clyde
C. F. Leslie	Clyde	Edw. Tourigney	Aurora
F. A. McDonald	Aurora	A. J. Weaver	Concordia
A. R. Marcotte	Concordia	F. E. Way	Concordia
W. B. Newton	Glasco		

Clay County.

D. P. Cook.....	Clay Center	J. A. Phillipsen	Clifton
S. M. Edgerton	Leonardville	S. Reynolds	Clay Center
M. W. Harner	Clay Center	S. W. Schenberger....	Industry
R. C. Harner	"	R. A. Stewart.....	Idana
R. J. Morton	Green	T. E. Schwartz.....	Clay Center
B. F. Morgan.....	Clay Center	J. P. Stewart	Clay Center
X. Olsen.....	Clay Center	G. A. Tull.....	"
M. C. Porter.....	"		

Crawford County.

L. P. Adamson.....	Girard	A. C. Graves	Pittsburg
A. O. Blair.....	Pittsburg	Frances A. Harper ..	Pittsburg
H. M. Bacon.....	Nelson	D. A. Iliff.....	Cherokee
H. H. Bogle.....	Pittsburg	F. L. Keeler.....	Farlington
C. M. Bertholf.....	Cherokee	Arthur Moberg.....	Pittsburg
H. B. Caffey	Pittsburg	A. M. Smith.....	Cherokee
C. E. Cole	Girard	M. K. Scott	Frontenac
H. K. Cowan	Midway	J. G. Sanddige.....	Mulberry
J. J. Cavanaugh	Walnut	C. R. Tinder	Englevale
A. A. Dickinson	Pittsburg	Wm. Williams	Pittsburg
R. B. Gibb.....	Pittsburg		

Cowley County.

H. C. Binson	Maple City	T. A. Jacobus	Winfield
Chas. Dunning.....	Arkansas City	W. H. Monser	Binden City
E. F. Day.....	Arkansas City	C. E. Pugh.....	Winfield
J. H. Gwinn.....	"	C. T. Ralls	"
F. B. Emory.....	Winfield	H. L. Snyder	"
C. M. Holcomb.....	Winfield	G. P. Wagner	Dexter City
T. E. Hinshaw.....	"		

Coffey County.

J. C. Fear.....	Waverly	V. McMillin	Burlington
C. L. Davidson.....	"	D. B. Rowe	LeRoy
A. K. Berry	Burlington	H. T. Salisbury	Burlington
B. E. Egan	Waverly	G. R. Norris	"
W. H. Mathis	Waverly	M. L. Stockton.....	Gridly

Dickinson County.

E. E. Hazlett.....	Abilene	Leslie Leverick.....	Solomon
J. N. Dieter	"	F. M. Gaines.....	"
Simeon Steelsmith ...	"	J. C. Klepinger.....	Herrington
P. B. Witmer.....	"	J. N. Ketchersid ...	Hope
Chas. B. Buck	"	Geo. E. White	Holland
J. R. Conklin	"	W. A. Klingberg	Elmo
Royal McShea	"	S. N. Chaffee	Talmage
John J. O'Brien.....	Chapman	F. W. Montgomery...	Navarre
J. D. Riddell	Enterprise	A. S. Gish.....	Abilene
A. R. Marcotte.....	"	Schuyler Nichols.....	Herrington

Dickinson County—Continued.

W. M. Van Scoyoc .. Manchester G. Greenlee Solomon
A. F. Hoover.....Enterprise

Doniphan County.

A. Herring Highland R. R. Clutz..... Bendena
J. H. McGahey Whitecloud T. E. Horner Severance
J. H. Hobson..... Whitecloud

Douglas County.

E. J. Blair.....	Lawrence	Jas. Naismith	"
H. L. Chambers..	Lecompton	E. D. F. Phillips	"
J. P. Gergen.....	Big Springs	B. H. Leslie	"
H. T. Jones.....	Lawrence	C. J. Simmons	"
G. W. Jones.....	"	A. W. Clark	"
G. A. Hammon	"	S. C. Emley	"
F. D. Morse	"	Carl Phillips.....	"
E. R. Keith	"	A. J. Anderson	"
E. Smith.....	"	A. Gifford.....	"
F. D. G. Harvey	"		

Elk County.

W. H. Smithers.....	Moline	C. W. Maddox.....	Longston
W. C. Trowbridge....	Howard	B. R. O'Connor.....	Grenola
J. L. Hays	"	M. G. Fox	Elk Falls
J. F. Costello	"	G. H. Grimmell.....	Howard

Greenwood County.

L. S. Trusler.....	Fall River	F. H. Hale	Fall River
N. S. McDonald	Severy	S. L. Axford	Virgil
S. F. McDonald.....	"	J. S. Black	Madison
D. F. Butcher	"	W. F. Hover.....	Climax
B. L. Hale	Neal	J. R. Pusey.....	Quincy
W. T. Grove	Eureka	W. H. Yandell.....	Piedmont
H. W. Manning.....	"	A. B. Lewis	Hamilton
E. J. Norman	"	J. M. Wiengar	"
W. S. Moonlight	"	C. L. Katz	Madison
J. Dillon	"	D. R. Campbell.....	Severy
Jas. M. Moore.....	Madison	W. F. Hoover.....	Climax

Harvey County.

J. T. Atxell	Newton	J. W. Graybill	"
Max Miller	"	L. T. Smith	Newton
G. D. Bennett	"	S. S. Haury	"
F. L. Abbey.....	"	A. E. Hertzler	Halstead
O. W. Roff.....	"		

Harper County.

J. C. Bowels	Bluff City	A. E. Walker.....	"
Benj. F. Hawk	"	B. H. Jordon	Waldron
C. W. Windbigler	Harper	J. A. Hazle.....	Freeport
G. M. Wooden.....	Anthony	A. J. McAdams	Harper
A. D. Updegraff	"		

Jewell County.

A. B. Peters.....	Mankato	C. R. Spain	Jewell
Dorothy D. Allen ...	"	J. E. Blodis	Randall
L. A. Carter.....	Randall	J. W. Johnson	Formosa
O. W. Hughes	Jewell	J. E. Hawley	Burr Oak
H. M. Hittner	Esbon	Chas. Hershner	North Branch

Jackson County.

V. V. Adamson	Holton	J. E. Love.....	Whiting
W. P. Brockett	Mayetta	J. W. Murray.....	Hoyt
H. F. Carver.....	Circleville	R. Robson	Mayetta
E. T. Myers	Netawaka	J. W. Darlington....	Dennison
Geo. E. Lock	Holton	J. R. Mainz.....	Whiting
E. W. Reed	Holton	F. W. Noble.....	Circleville
Chas. W. Reynolds....	"	J. C. Shaw	Holton

Jefferson County.

W. A. Aitkins.....	Valley Falls	Chas. F. Martin.....	Winchester
J. B. Armstead	Winchester	E. C. Rankin	McLouth
L. Atwood	Meriden	W. D. Groff	Nortonville
W. L. Barst	McLouth	P. Burns.....	Perry
G. W. England.....	Valley Falls	J. L. Work.....	Meriden
S. Johnson	Oskaloosa	Ira Puderbaugh.....	Ozawkie
A. D. Lowry	Ozawkie	M. S. McCreight	Oskaloosa
A. G. Smith	Oskaloosa	W. S. Hunter.....	Valley Falls
D. D. Wilson	Winchester	C. C. Kerr	Perry
J. T. Fulton.....	Donovant	L. V. Sams.....	Rock Creek
A. C. Zimmerman ...	Perry		

Johnson County.

C. R. Fear.....	Gardner	Robt. M. Moore.....	Olathe
T. S. Greer.....	Edgerton	F. B. Stout	"
F. F. Green.....	Olathe	Jessie Thomas	"
Wm. C. Harkey.....	Gardner	H. E. Williamson ...	"
H. E. Hastings.....	Olathe	Carl Thomas	Spring Hill
Thos. Hamel.....	"	C. W. Jones	Lenexa
Geo. Jewett	Edgerton	J. R. Sloan.....	Stanley

Kingman County.

E. W. Hinton	Kingman	H. E. Haskins	Kingman
H. L. Mills	Pensaloosa	M. H. Haskins.....	"
J. W. Cheney	Kingman	A. R. Haas	Ellinwood
A. C. Johnson.....	New Murdock	S. W. Mossman	Cunningham
Ira D. Nelson	Spivey	J. S. Caldwell.....	Kingman
J. A. McLaughlin....	Norwich	C. W. Longenecker....	"
B. H. Jordan	Nachville	O. A. Duncan	Norwich

Lyon County.

G. A. Biddle	Emporia	T. G. Burris.....	Allen
T. C. Biddle.....	Topeka	L. B. Bushoug	Admire
J. C. Brickell.....	Americus	O. J. Corbett	Emporia

Lyon County—Continued.

H. E. Davies	Emporia	J. C. Hughes.....	Hartford
F. A. Eckdall.....	"	J. F. Hughes	"
T. A. Foncannon.....	"	C. F. Lusk	Lebo
J. I. Roberts....	"	H. W. Edgerton.....	Americus
C. D. Hatcher	Admire	G. M. Gafford	Emporia
Jacob Hendon	Strong City	L. S. Harvey.....	Dunlap
D. F. Longenecker ..	Emporia	D. M. Gafford.....	"
J. H. Page	"	J. H. Jaquith.....	Council Grove
J. M. Parrington	"	C. L. Stocks.....	Bushong
T. E. Welsh	"	T. O. Brown	Reading
D. L. Morgan.....	"		

Linn County.

L. R. Ashley.....	Pleasanton	G. W. Vail.....	Parker
S. H. Brooks	Mound City	T. W. Warner	"
H. L. Clark	Lacygne	C. P. Lee	Pleasanton
D. E. Green	Pleasanton	J. G. Wortman.....	Mound City

Leavenworth County.

M. L. Crozier	Lanning	J. W. Risdon	"
C. C. Goddard	Leavenworth	C. M. Moates	"
S. McKee	"	A. J. Smith	"
R. L. Roling	"	P. W. Darrah	"
H. J. Stacy	"	J. D. Miller	"
J. S. Wever	"	S. B. Langworthy.....	"
C. E. Brown.....	"	C. J. McGee	"
C. K. Vaughn	"	J. L. Everhardy	"
R. L. Igel.....	"	J. N. Phillips	Linwood

Labette County.

J. M. Kleiser.....	Parsons	E. W. Boardman	Parsons
T. B. Allison.....	"	G. W. Maser	"
Geo. S. Liggett.....	Oswego	J. C. Creel	"
E. E. Liggett.....	"	Albert Smith	"
L. B. Kackley.....	Parsons	G. W. Gabriel.....	"
R. M. Bennett.....	Mound Valley	J. W. Henderson.....	Labette
H. L. Markham.....	Parsons	Jas. Heacock	Parsons
C. F. Brady	"	P. W. Barbe	Oswego
M. L. Perry	"	J. T. Tinder	"
O. S. Hubbard.....	"	C. N. Petty	Altamont
A. L. Skoog	"	A. M. Painter.....	Parsons
J. B. Anderson	Chetopa	A. D. Smith.....	Parsons
R. L. Von Trebra ...	"		

Lincoln County.

O. W. Shalksolm.....	Sylvan Grove	G. W. Anderson	Beverly
Otto F. Dierker		H. M. Butler	Cedron
A. Heltner	Lincoln	A. W. Townsdin	Barnard
Jas. Loughridge.....	Lincoln	W. A. Hulen	Lincoln
H. L. Hinchley	Barnard		

Mitchell County.

F. M. Daily.....	Beloit	M. R. Spessard.....	Glen Elder
F. B. Home.....	"	M. R. Barst	"
E. N. Daniels.....	"	N. J. Saunders.....	Cawker City
D. S. O'Brien.....	"	E. G. Mason.....	"
E. E. Brewer	"	H. L. Ratcliff	"
M. J. Lobdell.....	"	S. T. Blades.....	Scottville ..
A. J. Seager	"	J. F. Allman	Simpson

Montgomery County.

P. H. Dalby.....	Havana	E. D. Tanquary	"
H. M. Casebeer	Independence	F. W. Shelton	"
W. E. Youngs	Cherryvale	Mary S. Martin.....	Coffeyville
J. A. Pingston.....	Independence	J. R. Scott.....	Independence
B. F. Masterman.....	"	Ida M. Scott.....	"
Ira B. Chadwick	Tyro	T. A. Stevens.....	Caney
D. W. Howell	Havana	J. N. Strawn.....	Elk City
M. A. Finley	Cherryvale	G. W. Seacat	Cherryvale
O. W. Demott	Independence	J. F. Gard	"
E. C. Wickersham....	"	A. A. Krugg.....	Coffeyville
W. C. Chaney	Independence	C. H. Fortner	"
J. H. Johnson.....	Coffeyville	G. J. Biglow.....	Caney
C. C. Surber.....	Independence	J. L. Barker.....	Jefferson
W. C. Hall	Coffeyville	W. F. Blewett	Caney
Mamie J. Tanquary ..	Independence		

Marion County.

L. A. Buck.....	Peabody	R. C. Smith	Marion
O. J. Furst.....	"	J. Werthner	"
L. T. Morrill	"	G. P. Marner	"
H. M. Mayer.....	"	Grant Myers.....	Lincolnville
Jas. Welsh	Tampa	S. E. McIntosh.....	Burns
S. M. Palmer	Florence	J. H. Seylor.....	Ramona
L. S. Wager	"		

Marshall County.

H. Vleets.....	Blue Rapids	D. Humfreville.....	Waterville
D. C. Dodd	Summerfield	H. Humfreville	"
M. C. Brawley	Frankfort	G. I. Thacher.....	"
J. L. Hausman	Blue Rapids	M. S. Thacher	Blue Rapids
W. R. Breeding.....	Marysville	J. W. Chambers.....	Oketo
R. S. Tillman.....	Blue Rapids		

Miami County.

J. D. Van Nuys.....	Osawatomie	J. H. Haldeman	Paola
S. L. Brooking	Paola	D. H. Johnson.....	"
W. E. Craig	Osawatomie	J. D. Walthall	"
N. C. Spurs	"	J. W. Kelly.....	Louisburg
L. L. Uhls	"	F. H. Redmond.....	Osawatomie

McPherson County.

Geo. R. Dean.....	McPherson	J. B. Alexander.....	McPherson
J. C. Hall	"	E. O. Smith	Marquette
A. Engberg	"	V. I. Vesling	"

Norton and Decatur Counties.

H. O. Hardesty	Jennings	R. H. Smith.....	Decatur
Chas. W. Cole.....	Norton	J. E. Hodgman	Long Island
J. J. Dallal.....	Norcatar	C. G. Brethounor	Norton
C. C. Funk	Jennings	W. C. Lathrop.....	"
W. M. Jones.....	Norcatar	C. S. Kenny.....	Norcatar

Nemaha County.

J. H. Brown.....	Centralia	J. R. Matthews.....	Oneida
D. H. Fitzgerald	Kelly	A. J. Best.....	Centralia
J. W. Graham	Wetmore	W. L. Carlyle.....	Sabetha
N. Hays	Seneca	C. M. Fisher.....	Burns
U. G. Iles	"	W. A. Haynes	Sabetha
Joseph Haig.....	Wetmore	I. H. McGill	Corning
J. C. Maxson	Goff	S. Murdock	Sabetha
H. G. Snyder	Seneca	H. Reding.....	"
Benj. Skinner	Nemaha	Geo. Hall	Baileyville
Preston Thompson ..	Corning	R. E. Wright.....	Bern
C. R. Townsend	Centralia	W. L. Shelton.....	Woodlawn
W. F. Trouton	Seneca		

Neosho County.

W. K. Mathis	Chanute	W. E. Barker.....	"
Geo. H. Brown.....	"	A. M. Davis	"
L. D. Johnson	"	H. E. Rakestrow.....	"
J. B. Edwards	"	E. A. Davis	"
M. A. Duncan	"	J. A. Palmer.....	Erie
R. A. Light.....	"	J. J. McNamara	St. Paul
W. G. Hoshaw	"	M. E. Lake.....	Erie
F. R. Hickey	"	G. W. Morgan	Kimball
O. M. Edwards.....	"	C. L. Randall.....	Morehead
J. C. Lardner.....	"	W. C. McConnell.....	"
P. F. Wellman.....	"	R. C. Henderson	Chanute
J. W. Barker	"		

No County Organization.

Geo. Nicholson.....	Plains	W. S. Grissell.....	Ransom (Ness)
M. S. Reynolds.....	Yates Centre	J. J. Hissem	Ells'wth (Ellseth)
O. O. Smith.....	Leoti		

Osborne County.

J. B. Armstrong.....	Portis	E. E. Eisenbise.....	Natomä
T. B. Felix.....	Osborne	J. H. Walker	Alton
E. O. Henshall	"	A. A. Thompson	Osborne
H. R. St. John	"	C. L. Ebnother.....	Downs
T. O. Felix.....	Downs..	G. W. Franklin	"
B. F. Chilleot.....	Osborne	R. B. Mays	Covert
A. C. Dillon	"		

Ottawa County.

C. B. Alpin.....	Delphos	Jno. Miller	Minneapolis
J. F. Brewer	Minneapolis	C. D. Vermillion	Tescott
A. L. Cludas	"	J. W. Simmons	Culver
G. E. Eye.....	Delphos	F. E. Roberts	Bennington
W. H. Lee.....	Ada	Fred Harvery	Minneapolis

Osage County.

J. M. Heller	Osage City	T. E. Schenck	Burlingame
Jas. Ball	Melvorn	D. B. Moore.....	Osage City
C. C. Seabrook.....	Burlingame	A. F. Harrison.....	Scranton
C. W. Mains.....	Overbrook	E. F. Milligan.....	Quenemo
J. A. Connor	Burlingame		

Pratt County.

C. F. Bucklin.....	Sawyer	E. A. Gaston	"
M. M. Lottridge	"	J. J. Douthart	Pratt
Jas. A. H. Webb.....	Preston	C. D. Rogers.....	Coats
Frank Peak	Pratt		

Pottawatomie County.

W. M. Reigel	Wamego	A. Cutright	Louisville
C. W. Randon	Havensville	P. T. Conlan	St. Marys
E. L. Simonton	Wamego	L. A. Summers.....	Wheaton
Benj. Brunner	Westmoreland	J. W. Lauch.....	Olsburg
W. P. Wilson.....	"	C. H. Koentz.....	Onago
E. T. Richardson	Onago	S. R. Toothaker	Wheaton
J. M. Jennings.....	Wamego	J. E. McManus	Havensville
J. W. Wilhoit	St. George	O. R. Searl.....	Belvue

Phillips County.

R. M. Finney.....	Kirwin	C. E. Nelson	"
D. D. Haggard.....	Phillipsburg	G. A. Van Diest	Prairie View
E. A. Nelson.....	"		

Rooks County.

J. C. Parker.....	Woodston	D. F. Stough	Stockton
E. E. Colby	"	Chas. E. Barber	Palco
N. L. Book.....	Stockton	F. K. Meade	Plainville
W. B. Callandar	"	G. R. Rice	"
D. L. Sackrider	Webster	Harry C. Brown.....	Webster

Reno County.

R. A. Stewart.....	Hutchinson	H. G. Welsh.....	Hutchinson
J. E. Stewart.....	"	S. H. Sidlinger.....	"
D. B. Southard	Huron	H. S. Justice.....	"
S. M. Calladay.....	Hutchinson	Virgil Beavers	"
H. J. Duvall.....	"	J. W. McGuire.....	"
J. E. Foltz	"	C. A. Mann	"
G. R. Gage.....	"	E. V. Adams	Plevna
W. H. Bauer	Sylvia	C. S. Evans.....	Partridge
W. F. Schoor.....	Huron	T. O. Blaine.....	Turon
C. Klippel	Hutchinson		

Riley County.

C. F. Little.....	Manhattan	J. R. Case.....	"
J. D. Colt	"	Wm. Reitzel	Cleburn
E. J. Lyman	"	C. H. Roberts.....	Randolph
E. J. Moffitt.....	"	G. H. Litsinger	Riley
W. D. Silkman	"	A. G. Henderson.....	Leonardville

Rice County.

C. J. Forney.....	Lyons	A. H. Bressler	Raymond
G. E. Bush.....	Geneseo	H. F. McLaughlin....	Sterling

Rawlins and Cheyenne Counties.

J. N. Melugin	Atwood	L. G. Graves.....	Atwood
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Republic County.

C. M. Arbuthnot	Belleville	C. E. Haggman	Scandia
J. S. Billingsly.....	"	J. H. Houk	Agenda
J. C. Decker.....	"	J. D. Johnson	Republic
J. W. Eckblad	Republic	Wm. Kamp	Belleville
D. E. Foristall	Republic	W. I. McFarland.....	"
T. C. Long	Mundon	J. C. Sherrard	Norway
W. G. Hanning	Belleville		

Sedgwick County.

C. E. McAdams.....	Wichita	J. D. Clark.....	"
J. M. Latta	"	A. H. Fabrique	"
J. C. Brown	"	J. E. Oldham.....	"
D. W. Basham	"	Martin Hagan	"
D. I. Maggard	"	Jacob Z. Hoffman....	"
G. C. Purdue	"	E. S. Hymer	"
F. J. Walker	"	A. L. Scoles.....	Mt. Hope
E. M. Palmer.....	"	Wm. Sterrett.....	Wichita
J. F. Gsell	"	S. M. Anderson	"
J. G. Dorsey	"	D. G. Buley	Valley Center
E. E. Hamilton.....	"	Greening.....	"
J. W. Cave.....	"	L. P. Warren	Clear Water
H. S. Hikok.....	"	H. H. Miner.....	Cheney
J. W. Kirkwood	"	C. M. Fullenwider....	Wichita
C. E. Bowers	"	Rob't Baker'	Mt. Hope
F. B. Lyons	"	S. A. Bass	Wichita
G. K. Purvis	"	F. S. Williams	"
C. E. Casewell	"		

Saline County.

N. D. Tobey.....	Salina	J. H. Winterbotham..	"
J. H. Winterbotham.	"	A. G. Anderson	"
W. S. Harvey	"	F. G. Lagerstrom	"
W. B. DeWees	"	O. R. Brittain	"
J. R. Crawford	"	E. R. Tuttle.....	"
J. W. Neptune.....	"	L. O. Nordstrom.....	Assaria
Howard N. Moses	"	A. J. May.....	New Cambria

Saline County—Continued.

E. R. Cheney.....	Gypsum	W. E. Fowler.....	Brookville
E. W. Hawthorne.....	"	E. J. Lutz.....	Salina
C. D. Armstrong.....	Salina	J. E. Metcalf.....	"
M. J. Brown.....	"	O. D. Walker.....	"

Southwest Joint Society.

I. C. Bredhoft.....	Ford	C. A. Milton.....	Dodge City
T. L. McCarty.....	Dodge City	R. T. Nichols.....	Liberal
T. C. Bowie.....	Hodgeman	A. B. Scott.....	Jetmore
C. B. Leslie.....	Meade	W. H. Graves.....	Dodge City
W. F. Lee.....	"	H. Whitworth.....	" "
C. E. McCarty.....	Dodge City	Hubert Fannon.....	" "
G. F. Johnson.....	Lakin		

Sumner County.

S. T. Shelly.....	Mulvane	T. H. Jamison.....	Wellington
H. A. Vincent.....	Corbin	W. M. Martin.....	"
Eugene Pile.....	Portland	J. M. Hunt.....	"
Melvin Collins.....	Oxford	G. R. Waite.....	Milan
R. A. McIlhenny.....	Conway Springs	I. T. Sabhart.....	Caldwell
F. M. Owens.....	Argonia	D. E. Kisecker.....	Caldwell
T. J. Hollingsworth.....	South Haven	F. B. May.....	Hunnewell
J. J. Sippey.....	Belle Plaine	H. E. Hoke.....	South Haven
W. E. Bartlett.....	"	W. H. Neel Jr.....	Anson
H. B. Morton.....	Mayfield	W. H. Neel Sr.....	"
F. G. Emerson.....	Wellington	E. N. Williams.....	South Haven
S. W. Spitler.....	"	J. F. Robertson.....	Caldwell
J. L. Halliday.....	"	E. G. Ferris.....	Conway Springs
J. A. Roe.....	"	E. A. Evans.....	" "
H. L. Cobean.....	Winfield	Jos. A. Robb.....	Ashton
L. F. Harmon.....	Wellington	R. H. Shippey.....	Peck

Smith County.

B. W. Slagle.....	Smith Center	F. M. Bilby.....	Kensington
D. W. Relihan.....	" "	W. H. Bostwick.....	Cedarville
J. A. McCammon.....	Reamsville	H. O. Hardesty.....	Reamsville
W. C. Bower.....	Lebanon		

Stafford County.

J. N. Rose.....	Stafford	M. M. Hart.....	Macksville
J. P. H. Dykes.....	"	Chas. S. Adams.....	St. Johns
G. W. Scott.....	"	F. S. O'Flyng.....	Seward
Cyrus Wesley.....	"	F. W. Trethbar.....	Hudson
J. F. McDonald.....	St. John		

Shawnee County.

H. L. Alkire.....	715 Ks. Ave	Ida C. Barnes.....	726 " "
Harriett E. Adams.....	621 " "	A. W. Carson.....	Dover
C. S. Andrews.....	727 " "	O. P. Davis.....	N. Topeka
J. A. Berry.....	725 " "	D. E. Esterly.....	735 Ks. Ave.
E. M. Brackett.....	605 " "	B. D. Eastman.....	605 " "

Shawnee County—Continued.

F. J. Ernest	Topeka	G. W. Hogeboom	Topeka
J. D. Freeman	"	H. H. Hazlett	"
L. Y. Grubbs	"	S. A. Johnson	"
Sara Greenfield	"	C. E. Judd	"
H. B. Hogeboom	"	J. M. Jamison	"
N. J. Taylor	Berryton	J. P. Kaster	"
W. A. Wehe	Topeka	J. P. Lewis	"
W. L. Warriner	"	W. S. Lindsey	"
H. A. Warner	"	L. H. Munn	"
C. B. Van Horn	Berryton	J. C. McClintock	"
G. M. Minney	Topeka	W. E. McVey	"
T. R. Hyatt	"	R. E. McVey	625 Ks. Ave.
W. W. Yates	"	C. A. McGuire	6WW " "
Robert Stewart	"	R. S. Magee	634 " "
C. W. Schwartz	"	J. E. Minney	" " "
J. R. Fay	"	G. J. Mulvane	613 " "
C. W. Stahl	Auburn	H. C. Miner	N. Topeka
S. A. Hammel	Topeka	M. R. Mitchell	"
J. H. Outland	"	W. C. McDonough	603 Ks. Ave.
J. B. Towers	"	T. W. Peers	807 " "
Josephine Eskom	"	L. M. Powell	700 " "
W. F. Bowen	"	R. S. Plummer	N. Topeka
W. L. Schenck	"	F. H. Schalle	517 Ks. Ave.
W. H. Righter	"	S. G. Stewart	621 " "
J. C. Bennett	"	W. D. Storrs	616 " "
E. U. Coldren	"	O. A. Taylor	226 Berryton
S. F. Millard	"	W. C. Van Camp	"
S. J. Crumbine	"		

Washington County.

E. Armstrong	Greenleaf	J. C. Rudolph	Lawrence
R. Algie	Palmer	W. S. Runkle	Washington
J. H. Hoover	Haddam	J. R. Matthews	Hollenberg
H. D. Smith	Washington	G. E. Tooley	Washington
M. H. Horn	Morrowville	R. W. Maintz	Linn
Wm. Jacobs	Washington	H. M. Ochiltree	Haddam
J. O. Chambers	Hanover	E. W. Shearburn	"
W. M. Earnest	Washington	C. R. Nelson	Washington
M. N. Gardner	Greenleaf	D. C. Tyler	Clifton
R. A. Williams	Washington		

Wilson County.

J. H. Allen	Neodesha	J. W. McGuire	Neodesha
E. C. Duncan	Fredonia	B. R. RiIey	Neodesha
A. C. Flack	Fredonia	O. D. Sharp	Neodesha
E. N. Martin	Benedict	J. C. Preston	Buffalo
J. L. Moorehead	Neodesha		

Wabaunsee County.

C. R. Silverthorn McFarland
 Geo. M. Jeffers Eskridge
 Chas. H. Milke Alma
 C. E. Menard Maple Hill
 G. H. B. Beverly Alma

A. A. Myer "
 O. E. Webb Paxico
 Geo. A. King "
 W. H. H. Smith Altavista

Wyandotte County.

B. M. Barnett Rosedale
 Martha M. Bacon Kansas City
 L. F. Barney " "
 F. P. Clark " "
 F. P. Campbell " "
 J. A. Davis " "
 J. A. Fulton " "
 J. W. Faust " "
 C. A. Foulks " "
 W. D. Fairchild " "
 G. M. Gray " "
 S. S. Glascock " "
 T. E. Hays " "
 Ottaker Huffman Argentine
 G. H. Hoxie Kansas City
 P. D. Hughes " "
 J. F. Hassig " "
 A. J. Lind " "
 R. C. Lowman " "
 E. J. Lutz " "
 C. J. Lidikay " "
 O. M. Longenecker Rosedale
 I. J. McCalman Piper

J. H. McGregor Kansas City
 L. D. Mabie " "
 Anna K. Masterman " "
 Jas. M. May " "
 J. O. Milner " "
 Z. Nason " "
 Jessie Newkirk " "
 A. S. Pavlish " "
 J. G. Poole " "
 G. W. Richards " "
 R. A. Roberts " "
 Thos. Richmond " "
 A. T. Swan " "
 J. E. Sawtell " "
 C. M. Stemen " "
 Preston Sterritt " "
 E. R. Tenney " "
 F. M. Tracy " "
 Jno. Troutman " "
 S. H. Thompson " "
 Hugh Wilkinson " "
 W. F. Waite " "
 C. L. Zugg Argentine

Western Kansas.

V. C. Eddy Colby
 F. A. Carmichael Goodland
 C. M. Miller Oakley
 C. S. Morsh Menlo
 A. C. Gulick Goodland
 F. H. Smith "
 W. J. Lewis Gem

D. R. Strover Quinter
 H. A. Straup Winona
 Wm. M. Beaver Colby
 D. M. Forbes Seldon
 E. J. Beckner "
 C. D. Blake Ellis
 C. H. Gillman Oakley

Members having recently joined the State Society.

W. T. Fletnitz Dorrance
 H. L. Steele Pittsburg
 C. J. Halm LaHarpe
 C. W. Rairdon Lewis
 E. C. Button Great Bend
 Geo. W. Lee Toronto
 A. R. Lash Ellenwood
 J. W. Bolton Iola
 T. H. Howell Ellis

J. H. McNaughton Gove
 H. M. Hall Lincoln
 O. C. Payne Humboldt
 L. A. Newton Chicopee
 Chas. Chapin Frontenac
 F. L. Depew Howard
 J. L. B. Eager Kansas City
 D. M. Smith Argentine
 D. E. Clopper Argentine

Members who have recently joined the State Society—Continued,

R. C. McClure.....	Argentine	B. E. Garrison.....	Sedan
J. G. Sheldon.....	Rosedale	W. T. Courtwright....	Sedan
G. L. Alexis Hamilton	Kansas City	Milton T. Evans.....	Sedan
D. W. Thompson.....	Kansas City	P. N. Whitney.....	Cedarvale
J. L. Gove.....	Newton	B. F. Finn.....	Cedarvale
R. S. Haury.....	Halstead	W. L. Jack.....	Chautauqua
E. E. Wuttke.....	Halstead	Fred Calhoun.....	Peru
W. S. Graham.....	Wetmore	W. L. McNaughton...	Elgin
C. A. Neighbors.....	Emporia	R. W. Melton.....	Hewins
H. M. Welker.....	Pratt	R. S. Lynn.....	Chautauqua
L. R. Selters.....	Osawatomie	Wm. Floyd.....	Peru
W. S. Crouth.....	Stafford	J. D. Stevens.....	Peru
T. W. Scott.....	Stafford	H. S. Lamden.....	Peru
G. W. Goss.....	Sedan		

Officers of County Societies, for the Year 1907.

County	President	Secretary	Delegates
Jefferson.....	S. E. Smith	L. V. Sams	S. E. Smith
Allen.....		G. C. Glynn	
Crawford.....	H. B. Caffey	F. A. Harper	
Labette.....	L. B. Kackley	O. S. Hubbard	
Barton.....	F. B. McCauley	E. E. Morrison	O. P. McPherson
Greenwood.....	J. Dillon	W. T. Grove	
Harvey.....	G. D. Bennett	J. L. Grove	
Reno.....		W. F. Schoor	
Stafford.....	J. P. H. Dykes	Cyrus Wesley	Cyrus Wesley
Pratt.....	H. M. Walker	Athol Cochran	
Sedgwick.....		Martin Hagan	
Elk.....	W. H. Smethers	J. L. Hays	W. H. Smethers
Chautauqua.....	G. W. Goss	Milton T. Evans	
Cowley.....	J. H. Gwinn	H. L. Snyder	
Lyon.....	D. L. Morgan	C. A. Neighbors	
Wyandotte.....	E. J. Lutz	F. Campbell	Preston Sterrett
Miami.....	S. L. Brooking	J. D. Walthall	J. H. Haldeman
Lincoln.....	G. M. Anderson	J. Loughridge	G. M. Anderson
Western Kansas..	V. C. Eddy	F. A. Carmichael	

Jottings.

Medical Education. Even Louisville is feeling the impulse of better things in medical education. The medical departments of Kentucky University and the University of Louisville have been merged. The University of Louisville has bought the buildings of Kentucky University with its good will and equipment, the consideration being \$40,000. The two faculties will be combined. The Hospital College of Medicine and the Louisville Medical College have also merged. The new school will be known as the Medical Department of Central University. Every occurrence is further evidence that adequate medical education requires both money and population. One medical school to 50,000 people is proving an exceedingly small proportion. In the successful schools at least 150,000 people are there to furnish material. The expense of the modern school is becoming enormous: \$300 per annum for each student in school of 50 students to the class is only a moderate estimate. The need of an endowment or state support is obvious.

Kansas City and Our State University. The University of Missouri has asked Kansas City for a bonus of \$150,000, and the control of the city hospital as a condition for establishing the clinical department of her medical school there. About this latter matter the Star has the following to say:

The question of City Hospital clinics has again become active through the appointment of a Council committee to carry on negotiations with the curators of the Missouri State University concerning the conditions precedent to the establishment of a state medical school in Kansas City.

The treatment of this question involves a very simple expedient, and that is a square deal for all and special privileges for none.

It has been more than intimated that the Missouri school desires to control the clinics at the public hospital. The statement that this is a misrepresentation borrows some plausibility from the fact any claim of that kind would have not the slightest groundwork, either in reason or justice. The Kansas University was the pioneer in the establishment of high grade medical work in Kansas City. That institution must not be discriminated against in the matter of clinics. It may be said that it was to avail itself of these advantages that the Kansas school came to Kasas City. Nothing but equal ward privileges in the city hospital would be right or equitable.

That sentiment is plainly dominant in Kansas City, and the Missouri school would only be harmed and placed at a disadvantage by seeking to compass any advantage whatever over the Kansas institution.—The Star, March 8, 1907

A Crying Shame. A card bearing the following announcement is being sent around to the physicians of our state in an envelope with a reprint of Dr. Emory Lanphear's of St. Louis:

The Hippocratean College of Medicine, St. Louis, Mo., a Medical Night school, chartered by the State of Missouri, to instruct in all branches of Medicine and Surgery, and to confer the degree of M. D. on graduates. This institution will also conduct a separate department for Midwifery in which lectures will be given both in English and German. Preliminary courses in both departments will commence soon. Special advantages are offered to all students who will matriculate at once. For particulars address Dr. G. Feigenbaum, secretary, 1620 Washington street; or Dr. J. E. Chambers, president, 918 Pine street; or Dr. Albert H. Koch, vice-president, apothecary and chemist, 401 N. Jefferson avenue.

We are the more grieved to receive this announcement because just now is the time when it is beginning to look as if medicine were to cease being a mere trade and were to become a real profession—with professional standards for entrance and graduation in the way of wide culture and attested refinement. Here is a chance where the voice of the profession may be raised to good advantage. A medical school cannot be started today without endowment and heavy financial support, that will in any degree benefit medicine as either a science or an art. Nor can a student encompass a course of medicine in night study in four or even six years, if his days are taken up with physical or mental exertion. Hence the proposition must be classed with "Good Old Dr. Carson's Temple of Health," which "trains" students in "vitopathy."

What Do You Think of this?—The following from the March issue of the American Journal of Clinical Medicine is so radical in its suggestion and its authors so prominent in medical affairs of the middle west that our organization must take some notice of it. Undoubtedly it will appeal to many,—but the question is, Are not the dangers attendant upon such an arrangement greater than its advantages?

It is said that Chinese physicians are paid to keep people well, and that it is considered a disgrace—a serious matter—if one of their charges becomes ill.

This attitude has much to commend it. Why should not the physician be charged with the duty of looking after everything that concerns the health of his clients? It is worth more, vastly more, to a person to be saved from a long, expensive and exhausting illness, which takes him away from business and renders him unfit for work, possibly for months, than to be doctored and nursed with the most assiduous care, even if he is brought triumphantly through at last. Even Willie will prefer to go regularly to school rather than lie in bed ten days or weeks with scarlet fever—with the chance of deafness or other permanent disability to be carried through life as a result of it.

If this matter were presented right I believe you would be surprised at the number who would jump at the chance of engaging you at a regular annual sum to look after their families; attend to their minor ailments, and prevent the more dangerous ones. How many a simple cold becomes pneumonia, simply because it is neglected in its inception from false ideas of economizing on the doctor's bill! How often a little attention

to the throat, or to the bowels, or to some other part of the body, would nip in the bud "jugulate" if you please, some commencing serious malady!

Talk it up! Explain the economy of it to some of your best families and you'll be surprised at the number who will jump at the chance to pay you \$25 to \$100 a year each to look after them. There's money in it for them as well as for you. They can afford to pay twice as much to be kept well as it costs them to get well and they'll see it if you present the matter right. That's money for you. That's modern. That's "up to date."

Now listen, Brother. The trouble with our profession is not so much overcrowding as it is a failure to grasp the opportunities that lie all around us. This is one of them. The late P. D. Armour paid his family physician \$5,000 a year—so we have been told—just to keep him in good working trim. Can't you find a few who will pay you \$25 to \$100 each for the same purpose? Of course you can.

Don't keep on bemoaning the past, kicking about the present and harboring pessimistic views of the future. Wake up! Look alive! There's an acre of diamonds all about you. Clean out, clean up and keep clean. Work! Don't let the other fellow, the prescribing-and-prescription-peddling druggist, or the "old woman of the town" skin you.

The Journal of Inebriety After thirty years of continuous studies of the disease of inebriety and drug taking begins its new decade by entering upon comparatively a new field of physiological and psychological therapeutics for the treatment of these neuroses. Arrangements have been completed by which The Archives of Physiological Therapeutics has been consolidated and will hereafter be published as a part of the Journal of Inebriety. This very able monthly has been developing parallel lines of study with the Journal of Inebriety. In the opinion of its managers its scientific value would be greatly enlarged by concentrating its work along some special lines. The disease of inebriety and its allied neuroses is a field of most practical interests, hence the Journal of Inebriety is selected as a medium for continuing the work of the Archives of Physiological Therapeutics.

Henceforth in addition to the various phases of this subject which the Journal has presented, the therapeutic effects of hot air, radiant light baths, electricity, massage, psycho-therapeutic measures, and other physiological means will occupy a prominent space. This effort to clear away the confusion and broaden the studies of therapeutic means for cure, will make the Journal of Inebriety one of the most practical and valuable visitors to every hospital and institution, as well as to all specialists who treat brain and nerve neurotics. We shall aim to present and formulate the latest studies and facts along these frontier lines and in this way lift the whole field of therapeutics out of its present impenetrable stage into one of rational therapeutics.—*Announcement.*

Internal Medicine. It is gratifying to note, and attention should be called to the fact in discussing the progress of medicine during the past

year, that internal medicine is rapidly receiving recognition in this country as a specialty. In Europe, "Innere Medicin" of the Germans has been looked upon as a specialty for many years. Altho, for a number of years there have been few physicians in our larger cities, who might in the true sense of the word, be considered specialists in this branch, only recently has a large number taken up internal medicine in the incipency of their careers. In the past, internists became such thru the elimination of other work. Now, however, hundreds are entering the field with a definite view to making internal medicine their specialty. We consider this the greatest evidence of the progress in medicine. The field is a broad one, and those entering it recognize the importance of the broadest possible foundation. It is unlike most of the specialties in that the diagnosis usually entails a most careful examination of the entire physical being. Not only this, the internist must be thoroughly posted in laboratory methods of diagnosis, which in itself promises to become a specialty in the not distant future. Every case, with which the internist comes in touch, calls for a careful examination of the important systems of the body, and the necessary laboratory examinations. The number of patients, therefore, that an internist can and should see is very limited, if he would do his work conscientiously. There is no doubt but that the sins of omission in the practice of medicine are vastly greater than those of commission. The greatest mistakes that are made are of a passive, rather than of an active character, are made thru ignorance. That physician who overlooks a beginning nephritis, a incipient tuberculosis or an early valvular lesion, thru an incomplete examination, commits by far a greater error than he who prescribes an overdose of a drug. The one is caused thru negligence, while the other may be caused thru one of those tricks of the mind of which we are all occasionally victims. It behooves the internist, therefore, to give to each individual patient who applies to him, a most searching examination, regardless of the character of the ailment for which he applies. In order to do this, it will necessary for him to content himself with a very limited number of patients and to measure his success rather by the quality of the work done than by the quantity. That internist or general practitioner who boasts of seeing in his private practice from forty to seventy patients a day is a menace to the community in which he lives. Tho his mistakes and oversights may never be revealed to him, they are numbered by the hundreds. Progress, then, in internal medicine, means something more than mental progress; it means something more than the perfecting of diagnostic procedures and therapeutic methods; it means moral progress, a desire to give to every patient an opportunity to use an ounce of prevention rather than a pound of cure.—Jesse S. Myers, M. D. in the Interstate Medical Journal, Vol. 14, No. 1.

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CHRONIC APPENDICITIS

And Its Relation to Symptoms Referable to Other Organs.

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It would seem that in the past ten years so much has been written on the subject of appendicitis in its various forms and phases, that the entire subject has been covered, and that any writer of the present day, who has the temerity to attack the subject, should preface his remarks by an apology to the profession for presenting a theme so so widely and so scientifically discussed. It is not at all remarkable that pathologic condition, hitherto practically unknown, or at best but imperfectly understood, discovered simultaneously with, and in many cases dependent for its relief upon the phenomenal advances in the technique of abdominal surgery in the last twenty years, should attract the wide spread attention and offer the inducements for study, that this morbid condition has afforded.

No more striking evidence of the interest it has awakened in the entire medical field can be adduced than the numerous exhaustive monographs written by pathologists, surgeons and internists from their individuals' standpoint. The etiology, symptoms, and pathology of the condition have been set forth time and again, until, in the effort to make the subject more complete, or to contribute some original observation, a great deal that is inconsequential has been added.

The salient features of its symptomology have been so thoroughly impressed on the minds of medical practitioners that it is seldom mistaken for another condition. The true significance of abdominal pain, nausea and perhaps vomiting, followed later by localized tenderness over the appendix region, rectus rigidity and perhaps temperature rise, are seldom misinterpreted, provided, as pointed out by Murphey, these symptoms occur in the order named, but it has not been sufficiently emphasized that appendiceal involvement may exhibit a variety of symptoms other than these that may at times prove extremely puzzling, nor is it so commonly recognized that the various phases and graduations of the disease exhibit many peculiarities that are distinctly confined to, and dependent upon, the particular pathology of the morbid process, the immunity or involvement of other structures, the type and virulence of the primary bacterial excitant, or the acuteness or chronicity of the condition.

We are unable to determine from the character of the initial symptoms, the pulse, temperature curve, or blood examination, the probable termination of any case in its inception. The utter unreliability of all signs and symptoms from a standpoint of prognosis, constitutes the indication for the early operative interference which is now almost universally advised. It cannot be denied that the fear of this condition on the part of the laity in general, together with its frequency in general practice, leads to the diagnosis of appendicitis in many cases of acute abdominal pain without proper premises. On the other hand, its occurrence has been so frequently noted without the presence of pain especially referred to in the abdomen, as to no longer occasion comment, and the literature abounds in cases exhibiting typical symptoms.

A cursory glance at the anatomy of the right lower abdominal quadrant, would impress one that conditions requiring differential diagnosis from appendiceal involvement are comparatively few. A closer and more painstaking study, however, of peculiarities of vascular and lymph supply, nerve distribution and peritoneal investment, together with the different positions the appendix may occupy this area, will account in a measure for the variety of clinical phases this condition may assume, and the number of other diseases it may simulate.

In recent years we have come to recognize the fact that there is no condition so difficult to differentiate from the symptoms and physical findings as certain cases of right sided tuberculosis, renal calculus and appendicitis. In many cases of renal and ureteral involve-

ment, the attacks of pain, abdominal rigidity, nausea, vomiting, localized tenderness, obstipation and sometimes elevation of temperature, present the classical symptoms of appendicitis. On the other hand the urinary disturbances frequently associated with chronic appendicitis, with pain reflected to the genital region, inner aspect of thigh and the frequent presence of red blood corpuscles in the urine, as pointed out by Schlesinger (*Zar differential-diagnostic Zwischen Niersekrankungen and perityphilitis. Dutch Med. Wöch.* 32nd. No. 44) afford ample grounds for the diagnosis of renal or ureteral involvement. In many of these cases we have no positive diagnostic factors, the presence of intense pain reflected in the genitals and hematuria, while strongly presumptive is not conclusive, in the absence of renal tenderness or involvement of the renal structure, neither can the absolute absence of all urinary findings and of tenderness over the kidney be justly held to exclude its presence.

Freeman (*Jour. A. M. A.* Dec. 22, 1906.) has cited several cases of renal tuberculosis operated by him, in which the diagnosis of appendicitis had been made by competent men and I have in mind at the present time one of my patients operated upon two years ago who has since experienced two undoubted attacks of renal colic. Whether the two conditions were co-existent or whether the symptoms and physical findings simulating appendicitis were unusual prodromata of nephrolithiasis, it is impossible to say as the urinary findings were negative, the appendix pathologic and the patient free from all symptoms for a year after operation.

It is the purpose of this paper to consider briefly the subject of chronic appendicitis, its comparative frequency, symptoms, gross pathology and its relation to symptoms not commonly referred to the appendix itself. The purpose of the cases reported being to illustrate the occurrence of chronic appendicitis without history of an acute attack and without symptoms directly referable to the appendix itself, the diagnosis in each case being unequivocally sustained by the gross pathology of the appendix and the post operative history.

Case 1. Aet. 25, Stockman.

Two years prior to the time I saw him he began to suffer from pain high up under the right costal arch. The pain was not so severe but was greatly aggravated by horse back riding or jolting from any cause. In May 1904 his condition became so annoying that he went to Kansas City for treatment. He stated that his physician there told him that he had "Catarrh of the liver and stomach," that he took medicine for some weeks with apparent benefit, and later returned home wearing a broad belt around the waist

that seemed to give him some relief. During the entire time, however, he had suffered a gradual loss of flesh, his bowels had been obstinately constipated, requiring drastic purgatives, appetite fickle, tongue rarely free from coating. On the night of May 20, 1905 I was called to see him and found him suffering from a typical attack of appendicitis. In addition to the usual point of tenderness over the appendix, the gall bladder region and a point corresponding to the duodenal opening of the common duct were extremely tender. Immediate operation was advised and rejected, and he was treated by the starvation plan and opium with local applications of ice. The persistence of temperature with occasional slight rigors and the gradual development of an indurated area in the right iliac fossa, caused me to again urge operation to be undertaken as soon as he could be removed to his home in a distant town to which he consented.

Operation June 1.—Incision directly over indurated area, many old dense adhesions encountered which bound the appendix so firmly to the antero-internal aspect of the caecum that its separation was extremely difficult. The majority of the adhesions were avascular except at the point of the appendix where the recent process had resulted in almost complete necrosis of the tip and a small peri appendicular abscess firmly walled off by recent adhesions. The appendix was removed, abscess cavity thoroughly mopped out with dry gauze sponges and drained with a cigarette drain, drain removed in 72 hours. The appendix was 8 c. m. long, its walls were thickened, rigid and inelastic, the mucosa apparently destroyed in its proximal portion and several bands of scar tissue, the result of previous inflammatory attacks had resulted in an almost complete obliteration of the lumen. The extensive metaplasia, as well as the character of adhesions showed conclusively that the condition had been in more or less active existence for some time. The tip of the appendix exhibited the phenomena of a recent inflammation. The patient's recovery was complicated by a small fecal fistula due in all probability to the separation of old adhesions, which closed spontaneously in four weeks. Patient gained rapidly in weight and has been perfectly well since.

The case might be considered an example of the pre appendiceal stage or rather of a chronic appendicitis with an acute exacerbation. The condition had been of two or three years standing, and there had never been pain referred to the appendix itself, pain and soreness being referred to the lower border of the costal arch and epigastrium. He had never noted tenderness over the appendix but that such tenderness could have been demonstrated there is no doubt.

Case 2, R. C. Boiler Maker, Aet. 36 M.

First seen in May 1905. Three years previously began to have trouble with stomach and bowels. Complained of general dyspeptic symptoms, constipation, soreness across bowels, flatulency and headaches. These attacks would occur at intervals of one or two months and when established would continue at times for three or four months. During this period he would be unable to pursue his trade. To the symptoms noted above were gradually added a train of neurasthenic symptoms similar to those so commonly noted in prolapse of the kidney or Glenard's disease. Examination showed

a robust man slightly reduced in flesh, skin flabby and harsh, lungs reflexes, heart and glandular system negative. Palpation over the abdomen elicited extreme tenderness over appendix, also inability to take a long breath with the fingers inserted deeply under the right costal arch, and a point of extreme tenderness corresponding to the duodenal opening of the common duct. These findings, together with the general symptoms seemed to warrant a diagnosis of a cholecystitis (probably calculous though no definite history of colic could be elicited) concomitant involvement of the appendix. Operation was advised and rejected, the patient going to Kansas City where he was treated for the various "catarrhs." Eight months later having failed to find relief, the patient presented himself requesting operation. The physical findings were somewhat altered, the tenderness over the appendix increased while that over the gall bladder and choledoco-duodenal orifice, while still present was less pronounced. It was suggested to me that, as the patient's general symptoms were unabated and while the active morbid process in the gall bladder region was apparently subsiding, and the condition in the region of the appendix progressing, that perhaps the appendix was the primary exciting cause of all the symptoms. Operation showed a chronic appendicitis without peri-appendicular involvement. The peritoneal covering of the appendix was apparently normal. Its lumen, however, showed involvement of its entire length. Palpation of the gall bladder showed its walls thickened but no pericholecystitis or calculi. Complete recovery and freedom from all symptoms followed, the nervous symptoms being the last to disappear, occupying about five months in their subsidence.

This case gave no history of an acute attack and the general dyspeptic symptoms of which he complained were such as are commonly associated with calculous cholecystitis. Of interest in connection with this case is the neurosthenic element which I have noticed in connection with so many cases as to consider it a part of the symptomatology in all cases extending over a period of two or more years.

Case 3, E. W. Aet. 36, Farmer.

Complained for two years of symptoms chiefly referable to the bladder region, soreness and heaviness, frequent micturition, and occasionally some dysuria, more troublesome in the morning than in the after part of the day. Had treated for over a year for "Kidney and bladder trouble." Patient was reduced in flesh, had some vague dyspeptic symptoms, but was not constipated. Repeated urinary analysis failed to demonstrate any abnormality. Examination demonstrated a very tender appendix but was otherwise negative.

In the absence of other findings, it was thought advisable to remove the appendix. Operation showed an extremely long stringy appendix hanging over the pelvic brim, with many old adhesions but without adhesions to the bladder. This case gave no history of any attack of acute pain that might be construed as a preliminary attack, nor had he ever noticed pain or soreness over the appendix region.

His recovery was uneventful with complete disappearance of all symptoms.

Case 4, E. I. Male 21 years, Farmer.

For three months had suffered general dyspeptic symptoms, constipation,

headache, etc., which he described as "Feeling bad all over." Had never had any attack of abdominal pain that he could recall. About a week previous to the time I saw him he began to suffer with severe pain in the lower toracic region. Thinking he was threatened with pneumonia I was summoned. Examination showed a strong, robust young man. Heart, lung reflexes, normal; complaining of severe, more or less continuous pain somewhat diffuse in character involving the epigastric and lower costal region in front; not influenced by pressure except over lower border of liver, where patient complained of slight tenderness or deep palpation. The appendix area was very tender, and patient complained that even gentle palpation intensified the Epigastric pain. Though there was marked rectus rigidity and superficial hyperaesthesia, patient said he had never noticed pain or soreness in the area before. Operation was advised and performed one week later, the epigastric pain continuing in the interval. The appendix showed little involvement of its serosa but the mucosa was inflamed throughout its entire length and beginning ulceration could be distinctly determined.

Recovery was uneventful with complete disappearance of symptoms.

Case 5, E. K. Farmer 24 years.

Came into my office at 11 a. m. Complained of trouble with stomach and bowels. Examination showed strong, robust young man. Physical examination negative except pronounced tenderness over appendix. Patient had never had any attack of abdominal pain, nor felt tenderness over the appendix area. He had suffered from attacks of vomiting at times, but these attacks had never been associated with pain, bowels had been extremely constipated requiring almost daily medication to secure a movement.

Operation was advised and performed that evening. The appendix was slightly adherent, thickened and inflamed. Recovery uneventful with prompt disappearance of all symptoms.

These cases briefly recorded are only a few of the many cases that I have met with in my practice. The vast majority reject operation and question the diagnosis because they have never had acute abdominal pain and because the symptoms are not sufficiently distressing in their estimation to justify an operation. The usual course and history of these cases is that they run the gamut of the various therapeutic measures of the internist with little benefit and pass into the patent medicine stage of the disease where they revel for a time in the seductive claims and cure-all promises of Swamp Root and Peruna. Ultimately many of them return seeking operative relief after the various measures they have tried have failed utterly. Many of them continue to go about, their condition remaining practically unaltered from year to year, an ever ready and anxious source of revenue to the doctor who wishes to prescribe. Gradually the constant discomfort and impaired nutritional excre-

tive functions give birth to a train of neuresthenic symptoms that frequently become the most marked feature of the disease. Not infrequently a severe and acute appendiceal attack brings the patient to the surgeon with the realization that his condition is really serious and demands treatment.

While it is generally conceded that infection of the biliary channels frequently result from certain bowel conditions, as found in typhoid, pneumonia, influenza, dysenterry, etc., the search light of recent investigation has been but recently directed toward the methods of transmission of infective agencies originating within the lumen of the intestinal canal or its peritoneal investment. The remote effects of the *B. typhosus* in the production of cholelithiasis and bile tract infection, and the frequency with which this organism has been found in the bile have been long recognized and amply discussed. The agency of oemebaiasis in the production of single and multiple abscess of the liver is beyond dispute. More recently, the effect of long standing disease of the appendix as a probable factor in the production of biliary infection has been forced upon us by the surprisingly large number of cases in which we find these two conditions associated. The older theory of the method of cholangic infection by way of the common duct is being displaced by the knowledge that infection of the biliary passages may and does occur much more frequently through other channels. Of these, the portal vein, the systemic circulation and the lymphatics, may each under proper conditions be the carrier of the invading organisms.

Experimentally it has been conclusively demonstrated that the bile passages may be infected by bacteria introduced into the portal vein. Clinically it has been proven that infection sometimes occurs through the systemic circulation, but the question of infection through the lymphatic channels is still denied by many and doubted by nearly all. In order to establish a premises for the contention that such infection does occur, many accepted theories as to the lymphatic conditions in the vicinity of the appendix must be revised. Rippert and Zuckerkandl have stated that the lymph follicles of the appendix region gradually disappear and are obliterated and that the adenoid tissue in this region undergoes a metaplasia and disappears about the age of twenty. While we can find very little in the literature at the present day to sustain the contention that lymphatic infection does occur, it will be admitted that the persistence of adenoid tissue in this region exceeds the time limit placed upon it by earlier writers, and we are convinced from the

pathology of certain types of appendiceal involvement that the rapid and extensive involvement of other structures in the immediate vicinity could only be logically ascribed to infection through lymphatic channels.

That infection of areas remote from the appendix, and where such infection could more reasonably be ascribed to dissemination via the lymphatics than to continuity of tissue, thrombo phlebitis or definite favoring anatomic conditions exists, we have abundant evidence in certain cases of sub hepatic and sub phrenic abscess formation, arising primarily from appendiceal infection. While it may be admitted that the anatomic conditions in the immediate neighborhood of the appendix as regards lymphatic supply do not seem to favor the theory of infection spreading through the channel, we have no warrant for the supposition that this organ is without lymphatic complement. Murphy (Practical Medical Series Vol .2, Page 395) has described the occurrence of a typical lymphnode in the meso appendix.

It has been generally held that there is no connection between the lymphatic of the liver and those of the appendix region, the usual course of the lymphatics of the liver from the surface beneath Glisson's capsule to the base of the suspensory ligament or sub hepatic glands precluding the possibility of continuous lymphatics connection. Terrier and Cuneo, however, have demonstrated a peculiarity in lymphatic distribution of the lower costal region of the right lobe which would make infection by this route not only possible but highly probable. They found that those lymphatic radicles do not pursue the usual course, but pass directly into the liver substance and their glands accompany the portal vein to the hilum. This could readily explain a route by which bacteria could reach the liver and infect the biliary stream.

The destructive influence exerted on invading bacteria by the liver cells themselves reinforced by leucocytic activity and the natural antiseptic properties of bile, which acting as protective factors in a way, directly favor the occurrence of bile passage infection by so reducing the number and virulency of the invading microorganisms as to make them innocuous were it not for bile stasis. This stasis occurring usually in the gall bladder produces conditions extremely favorable for microorganisms of attenuated virulence, to initiate mild inflammatory conditions by a process of sedimentation analagous to that of tuberculosis in the pulmonary apices, and thereby supply the requisite conditions for the establishment of insidious inflammatory processes resulting in the formation of biliary

calculi or chronic non calculous cholecystitis. Sheldon (Journal A.M. A. Nov. 3, 1906) showed that in 39 out of 46 cases operated by him for cholecystitis, calculous and non calculous appendicitis was demonstrated.

While the number of cases reported is comparatively small, yet their significance is no less striking and confirmative of the role played by chronic appendicitis in bile tract infections. He considers that the lymphatic system plays no important part as a carrier of infection, yet Muller (Brooklyn Med. Journal 1902-05) has demonstrated a very plausible theory of the method of biliary infection secondary to disease of the appendix through the medium of the lymphatics. Murphy holds that when a pus infection is transmitted to the liver through the Portal Circulation, a secondary process must be established before hepatic infection can occur, that is, a thrombo phlebitis and escape of the infective agent into the liver substance, however, bacteria of mild virulency may be transmitted through the Portal vein and reach the bile passages without the occurrence of this phenomena. Whatever the route of infection, it is to be borne in mind that infection is not only at all times the primary source of calculi formation but it is responsible also for complications following.

In the female involvement of structures within the pelvis are found as concomitant with involvement of the appendix in a surprising large number of cases. Peterson (American Journal of Obstetrics, 1904) from statistics based on a study of several hundred cases showed that 50 per cent. of chronic adnexal disease showed disease of the appendix and 70.9 per cent. of ovarian cystoma exhibited the same phenomena. These statistics are strikingly suggestive to say the least as we are unable at the present time to state definitely which pathological process antedated the other.

In relation to the various symptoms of chronic appendicitis, many of which cannot be directly traced to disease of this organ, but in many cases are typical in their symptomatology of disease of other structures, but which are known to disappear entirely upon removal of the appendix, it would seem that the following deductions are justified:

1st.—Chronic appendicitis may occur without the precedence of an acute attack and may be absolutely latent as to symptoms directly referred to the appendix.

2nd.—Cases presenting such symptoms are likely to be classed as dyspepsia, gastric or intestinal antony, the various catarrhs, chronic constipation, torpid liver, etc., unless a careful and thorough examination is made.

3rd.—Chronic appendicitis of long standing presents in many cases distinct neurasthenic symptoms of gradual and progressive development, and these as a rule are last to disappear after operation.

4th.—That in the majority of cases this condition, while not directly threatening as to life, results in discomfort and physical deterioration and seriously interferes with metabolism and the pursuit of the patient's avocation.

5th.—That the general trend of the condition is not towards spontaneous cure, but is marked by periods of almost complete absence of symptoms and at other times entailing such discomfort and disability as to absolutely unfit the patient for any kind of work, and the morbid process when once established is likely to be progressive and permanent with a tendency to later involvement of such other structures as the bile passages and in the female, the uterine appendages.

6th.—That medical treatment while at times giving some relief from symptoms is at best but palliative and not curative and in the main is unsatisfactory, time consuming and of little real benefit.

7th.—That in the face of recent statistics the significance of this condition as a factor in the production of morbid processes in other organs cannot be ignored, and as such, demands serious consideration.

8th.—That it has not been demonstrated that the removal of the appendix even remotely affects the health or injures the nutrition, and its removal when accomplished with the observance of a proper technic entails but a very slight risk to the patient and does not appreciably prolong the operation, its removal in all abdominal operations (within a given age) where there is a probability of its being diseased or a possibility of its proving a future source of trouble is not only permissible, but advisable providing, always of course that it can be readily brought into view and the patient's condition on the table does not contraindicate the slight additional trauma.

Guides to a Diagnosis.

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Pasteur says: "I do not know; I will investigate." Faraday says: "First, tell me what I am to look for."

What we already know we do not have to look for. What we do not know is best and quickest found out by a practical system of investigation, or method.

A system of investigation is made up of rules and axioms established by observation.

The rules in medicine and surgery are comparatively few and easily learned; a consideration of their exceptions requires a lifetime of vigilance.

The determination of pathological or abnormal conditions is the salient object of every medical and surgical investigation as a true understanding of these conditions is essential if we would claim credit for the relief of the sick and afflicted.

It is sometimes a very difficult task to accurately determine the true departure from a normal standard. What seems to be markedly abnormal in one patient might be quite unimportant in another individual whose surroundings were different, and one presenting a different physical make up.

To be able to determine with accuracy the various morbid conditions of the human body, is the highest qualification of the physician or surgeon. Such qualification requires experience acquired by practice and close observation.

The physician and surgeon has to deal with material forms; these material or tangible forms are guided and influenced by an intangible and invisible force instinct with life and intelligence, factors which render the problem of Physical Diagnosis vastly more complex and difficult of solution.

The physician and surgeon, to be properly equipped to cope with the various combinations of physical ailments that come before them for their consideration, should prosecute a vigorous and extensive study of Anatomy, Physiology, Pathology, Chemistry, Physics, Mental and Moral Philosophy. A knowledge of these branches

constitute the foundation for correct diagnostic conclusions. Having acquired a thorough knowledge of these indispensable aids, the diagnostician who exercises due caution, and possesses a sound judgment, may do credit to himself, justice to his patient, and honor the profession he represents.

A number of methods have been suggested by our numerous authorities on the subject. The two most commonly accepted methods are known as the analytical and synthetical. Quite often, however, a diagnosis is made almost intuitively by the pronounced nature of some particular symptom, especially where complications are absent, but in those obscure, complicated and masked conditions, where long continued drug action and other influences play a conspicuous part in the drama, where occupation and habits contribute their quota, together with an emotional nature freely given to magnifying and malingering every available means at our disposal, may fall short of a bringing rational conclusion as to exact conditions. However, with our improved methods of diagnosis, together with our knowledge of diseases and their unmistakable language (when uninfluenced as above suggested), a very satisfactory conclusion can be reached in a large per cent. of cases.

It is too often the case with most of us that an off hand or rather an intuitive diagnosis takes the place of a systematic or methodical investigation. The physician's time being short, short methods are adopted for the disposition of seemingly trivial cases. More failures in practice are due to hasty examinations than to faulty remedial agents; and while I do not demand an exhaustive investigation in every case that presents itself for medical attention, I do believe that the physician and surgeon should be armed with all the reliable diagnostic guides available. These guides may be obtained from a number of sources.

A diagnostic conclusion may sometimes be likened to a chemical experiment, when you have no definite knowledge of the nature of the article you are examining. The process is recognized as the working out of an unknown; an identification of the article facilitates the process, hence the necessity of knowing the personal and family history.

The "Anamnesis," as it is sometimes called, will disclose a number of land marks or guides to a correct conclusion.

Coming back to our illustration we find that certain reactions and effects are obtained by subjecting certain articles to certain influences, while if we change the article the treatment or process changes and the results are quite different. Just so with our diag-

nosis when nationality, occupation and habits of life are considered. For instance, susceptibility or immunity possessed by certain races, notably the liability of the Jewish race to diabetes; of the Scandinavian and African to phthisis pulmonalis, and the comparative immunity of the African to yellow fever.

Occupation has its special following according to its peculiar nature, whether active or sedentary.

Residence: Certain diseases have a special affinity for certain localities.

Habits: The habits of an individual cut no small figure in the estimation of pathological conditions.

Having attained these special advantages and equipments we proceed perhaps, by the analytical method by going back to the origin of the affection and tracing it down to the time of the investigation, or perhaps a reverse order may be pursued by considering the "Status Praesens," or present condition of the patient, and following back to the beginning of the trouble. This method is known as the Synthetical.

Another very useful method which we are sometimes forced to resort to is known as the exclusive method, which sometimes include both the above. A case of delirium tremens, for instance: Urinalysis shows no Albumin, thus eliminating Albuminuria. Face flushed and bloated, eyes congested, pupils evenly dilated and responsive to light; the extremities move normally, eliminating fracture and apoplexy; the test of alcoholism is applied which consists of a firm and steady pressure over the superior orbital nerve, gives intelligent response from patient; Conclusion: Uncomplicated alcoholism, determined by exclusion.

Diagnosis, like all other branches of medical science was at one time a mere system of guess work, but the same painstaking research that has raised other branches of the science to their high state of perfection, has contributed liberally to the establishment of this excellent branch of medicine.

Among the more common guides to a diagnosis may be mentioned those outward manifestations of disease known as objective symptoms; which taken in connection with the subjective symptoms, constitute the ordinary means of reaching diagnostic conclusions.

It might be well to mention the fact that certain difficulties environ the investigation of diseases arising from divers sources. Among others may be mentioned the reluctance on the part of the patient to communicate any information calculated to affect their physical or social standing, or that of those related to them by the

ties of consanguinity. This barrier can only be surmounted by the personal tact of the physician, who should be favored by a sympathetic manner, an insinuating address and other amenities which impart to character its loadstone attraction. The proper exercise of these special endowments will soon gain such a mastery over the will and affections of the patient that nothing will be withheld. Some practitioners are quite unfortunate, however, in never being able to secure the entire confidence of their patients, owing, no doubt, to their peculiar constitutional make up or manner of education.

The interrogation of a patient is often like that of a timid or unwilling witness in court—requires tact and ingenuity to secure the desired information. A very important object may be served by allowing the patient to tell his or her own story, providing they confine themselves strictly to the subject of investigation and avoid useless digressions, and matters irrelevant and non-essential to the inquiry. A privilege of this kind will sometimes disclose peculiarities of character very essential in our final estimation of the case. Questions propounded to the patient should be free from ambiguity and technicalities, and to insure brevity and exactness of statement no leading or suggestive questions should be asked.

Undue levity of manner should be avoided at all times. It is not to be expected that patients educated or uneducated should describe their feelings in grammatically constructed sentences, or use the most fitting words in describing their ailments. A neglect of this courtesy is liable to wound the feelings of the patient, and subject the individual physician to the charge of brutality, and the profession to a lack of sympathy.

The influence of disease on the morals of the sick is quite marked in some individuals, hence the necessity for making due allowances for deportment, which might be regarded as uncivil and inexcusable under normal conditions.

Age is one of our most important guides to a diagnosis. Take for example the resisting gum in dentition; the result of such irritation may manifest itself by the most disorderly and spasmodic action of the entire muscular system. Such phenomena occurring in the adult might be referred to quite a different source and create much greater alarm than when the subject is a child.

A pain in the child's knee would readily direct attention to the hip joint, while abdominal pains with grunting respiration would suggest the possibility of a disease of the vertebrae.

Cervical enlargements in the adult might be regarded as a

carcinoma or sarcoma while in a child Adenoma might be identified as the cause. Vesical irritation in the young might suggest urinary calculus while the same symptoms in the aged might be attributed to cystitis or an enlarged prostate.

The diseases peculiar to childhood are the different exanthemata, and inflammatory affections of the alimentary canal and respiratory passages—tonsilitis, diphtheria, laryngitis. Gastro-Enteritis are common in youth; while in middle life inflammatory conditions attacking the thoracic, abdominal and cranial viscera are most commonly met with. In advanced life the most common and characteristic conditions are those affecting the urinary passages and causing structural changes in the blood vessels.

Sex: The difference between the physical and psychical nature of the two sexes is quite marked in health and it is quite reasonable to expect that these peculiarities would be intensified under the disturbing influences of disease.

The emotional element predominates in the moral constitution of the female, while in the physical organization the sexual system. The influence of the latter on the former imparts a certain coloring to all morbid phenomena, hence it is necessary to consider this peculiar relationship when confronted by a case of convulsions in the female, as hysteria in the form of the hysteroidal joints, fictitious blindness, irritable bladder, etc., may tax our ingenuity, not so much for the relief of the patient, but to satisfy the minds of friends and those would be diagnosticians that frequently call themselves in consultation under the guise of friendship, but turn out to be mere curiosity seekers.

This special peculiarity of the female sex is more marked during the period of the greatest functional activity of the organs of generation. The same subjects taken after the climetric often become the victims to those formidable and real conditions known as the fibroids and carcinomas.

The male, in contrast with the above, enjoys singular exemption from hysteroidal attacks, as well as carcinoma. If man complains of a pain in a joint he generally has some real pain—rheumatism, gout or some other form of inflammation. Loss of motion in a limb means paralysis and not a simulation; if irritability of the bladder is complained of, there is usually some good reason for such complaint, such as stones, cystitis, or an enlarged prostate, etc.

While this physical picture is true in the main, the physician and surgeon should not conclude that because the patient is a woman her symptoms should be disregarded and ignored at all times.

Some very grave mistakes have been made by men eminent in their profession by regarding all subjective symptoms as a mimicry or a hysteroidal attack, because the patient was a female.

Occupation: Occupation is frequently a predisposing factor in the cause of disease, and sometimes determine the nature of the malady. A case of phosphor-necrosis of the maxilla would be expected when the subject is a manufacturer of lucifer matches, especially if a defective tooth exists. The painter, as is well known, is the subject of lead colic. The chimney sweep to soot-cancer of the scrotum. Diseases of the air passages are brought on by exposure to contact with certain irritable gases, as found in certain manufacturing establishments. The house maid from her kneeling position, is subject to enlargement of the patellar bursa. Plumbers, and those whose employment call them into wet or damp localities, are liable to rheumatism, etc.

Antecedent History: Nothing is better established than the transmissibility of disease—fortunes inherited may cling to some tenaciously, but the chances are that their fortune, however great it may be, will be squandered long before a transmitted disease is exhausted.

It sometimes happens that pathological or morbid legacies skip a generation and appear in the next, but this is an exception to the rule. There are people who exhibit symptoms of pulmonary disease, but in whom no detectable lesion exists, but going back into the antecedent history we find that a maternal or paternal ancestor, having died of tuberculosis, we have no hesitancy in advising a change of climate, (as well as doctors.)

Temperament: Temperament and constitutional peculiarities contribute their quota to the interpretation of morbid phenomena. The sanguine temperament, which is manifested by a strong and vigorous heart, a full and bounding pulse, a florid complexion and other signs of a dominating, vascular system is one predisposed to acute inflammation of various organs.

Recognizing these constitutional peculiarities, the physician or surgeon should be on the alert to anticipate and combat such complications as are liable to appear before they become entrenched. The patient may possess a phlegmatic temperament, recognized by a dark complexion, a sluggish circulation and blunted sensibility, with all mental and bodily movements conducted in a lazy and sluggish manner. Such individuals are sometimes quite indifferent to suffering, and disposed to endure their pain without a word of complaint or other demonstration. In such cases we are liable to under-

value the gravity of the disease until it is too late to successfully manage it.

On the contrary a reasonable discount should be allowed on those persons of a nervous temperament, characterized by quick movement, those restless individuals whose circulation is easily excited, and who bear pain badly.

There are other important facts to be considered in connection with the personal or ante-cedent history;—a joint becomes suddenly swollen and painful; the physician or surgeon might be at a loss to know how to account for the condition, but should it be ascertained that just prior to the beginning of the trouble the patient had received a severe blow upon the knee, or a sprain, the diagnosis would be quite clear.

Habits: The habits of individuals constitute no small element in the production of diseases. Affections which are the direct result of habits, vicious or otherwise, frequently require medical or surgical attention, which when recognized materially modifies the prognosis, and explains phenomena that if overlooked would render a diagnosis quite obscure.

Thus the defects of vision due to the excessive use of tobacco would, but for a knowledge of this practice, taking alone the appearance of the eye, excite serious apprehension for the future of that organ. A follicular pharyngitis due to this cause would be a great satisfaction to the patient if he understood the difference between it and one symptomatic of pulmonary tuberculosis. Purity or depravity of the patient known to the physician or surgeon will often clear the diagnosis in case of a discharge from the male or female genitalia, but there are exceptions to this rule, as it has often happened that an impure kiss from the lips of a syphilitic lover has stained the character and infected the system of many chaste and virtuous women.

Mind Over Matter: The influence of the mind over bodily functions should not be lightly considered. That there is to be found in a satisfied and tranquil mind a potent synergist in our battle with disease there can be no question. To this fact alone must we look for a reason for some of the so-called faith cures and the miraculous hypnotic claims.

To convince the patient that he is not sick serves to elucidate and confirm our diagnosis. This, however, would be similar to an exploratory operation in surgery. We would first have located the difficulty by intuition or otherwise, and exhibit such treatment as we would expect to confirm our diagnosis.

It is not the purpose of this paper to become metaphysical or occult, but simply desire to carefully consider psychological phenomena and their relation to bodily functions, which will serve to guide the diagnostition in many obscure cases.

Among some of the common evidences of psychical influences on bodily functions may be mentioned the suspended action of the salivary and other glands of the mouth and throat, brought on by a feeling of fear. Great mental anxiety or distress has been known to cause a marked suppression of urine. Grief so profound that an adequate description can not be attempted, from a lack of language and expletives to express it, has been denied the relief that often comes to some by a flow of tears, by the secretion of the lacrymal gland being completely arrested. Over worry with business cares will sometimes bring on irritability of the bladder.

A grave form of impotence has been the result of fright. A heart murmur has resulted from the communication of unwelcome tidings. The reparation of wounds and injuries are always retarded by the influence of fear, remorse and disappointment.

We sometimes find subjects with a highly wrought imagination associated with an ardent temperament, who are inclined to give an unreal or false coloring to their ailment which is calculated to mislead the unsuspecting practitioner.

Hope is a powerful cordial, a soothing stimulant and a strong and efficient antidote in many cases of sickness or injury, and the physician and surgeon should not fail to utilize it in all cases when it can be applied.

There are many other useful aids which might be mentioned that would serve as guides to a diagnosis. This paper is already too long, but it is respectfully submitted.

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BORDERLAND

Obsessions: Phobias: Impulses:

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What do we mean when we say that so and so has an obsession? In olden times when they had less "cult" they often spoke of some certain person being "possessed". I imagine that they were referring to about the same old thing as we do when we say an obsession. We had to go to France to get this name, so it ought to be good, being imported as it is. Probably our good old grandfath-

ers wanted to say the party was possessed by the devil, as all things not understood in those days were accredited to the arch enemy of man. Be that as it may, we are now to consider what these specialists mean, when called in consultation, by knocking the underpinning from under us by informing us that the patient has "an obsession."

To be literal the dictionary gives us this definition: Obsession (L. Ob. opposite, plus, sede're to sit) Possession by demon; a delusional possession. So after all our progenitors were right, it is the devil at the bottom of it. De Fursae says an obsession is constituted by an imperative idea associated with a state of anxiety, there being no marked disorder of the consciousness or judgment. The state of anxiety may precede the obsession, or appear with it. It generally is a part of the trouble when it occurs; but we have obsessions that are not accompanied by anxiety at all; this is especially the case in some of the chronic cases of obsessions of people that have been on the crank list for a decade, or so.

The mental aberrations characterized by these phenomena are voluminous in number; some trivial, others grave in character.

They only agree in this one particular, that they do not fall under any of the known classifications of mental psychoses. In these different obsessions we have the material implication of the intellect, but in all of them there is a decided nervous weakness, involving to a greater or less extent the function of that which we call the will. We seldom meet with these peculiar cases of obsessions in the asylums and hospitals, unless they are mixed up with other well marked mental psychoses. "There are probably few normal individuals who have not felt at least a suggestion of a morbid impulse under favoring conditions, or had a haunting idea that was not far from obsession at some time in their lives. They comprise a true borderland between mental sanity and disease, and are found well over both sides of the indefinite dividing line that separates these two states." (BB).

We have seen that, so far, in our course that we have patients that show eccentricities, crankiness and so forth; in these cases these peculiarities are indications of degeneracy, and in some of them there are mild forms of mental derangement; as from periodic insanity, or original paranoia. In other cases we find that the peculiarities are due to racial, or early training of the individual; or to peculiar environment. "There is, however, a certain number of eccentrics whose aberrations cannot be accounted for in either of these ways, and who make a class of disequilibrates, or, in common

language, "cranks." While they may never become actually insane in the legal or medical sense of the term, they are frequently the descendants or progenitors of lunatics, and the family history shows their real position on the borderland of mental alienation. These individuals are often mentally bright in some directions; many of the unbalanced or irregular geniuses are of this type. Others are mediocre in talent, and only exhibit a lack of mental balance that handicaps them in the competition for existence.

A very common peculiarity is in their writing—the undue use of italics, for example, so characteristic of a certain class of these dis-equilibrates. It is almost impossible, however, to definitely define them, as their symptoms and peculiarities are manifold, and they shade off imperceptibly into the average individuals. It is only when their abnormalities are rather striking that they can be reckoned as properly belonging on the borderland of insanity. It is rare for these persons to be in any sense dangerous or to require sequestration, except when as sometimes happens, the degenerative predisposition causes them to succumb more readily than others to attacks of actual mental derangement."

By reason of mental deficiency or a mental twist these cranks stand on the borderland of insanity and are more nearly allied to the paranoiacs and imbeciles than any other type of the psychoses.

The term obsession, again, includes not only the will, but, also, the emotions and intellect; but the latter are manifested in defects of will power. Some claim that they are hereditary, but, inasmuch as the propinquity to take on such troubles is on account of a peculiar makeup, it will do better to say that the tendency is hereditary and not the obsessions themselves. We must remember that we are all of us subject to morbid impulses and to besetting mental conceptions and obsessions, though often slight and transitory in character and we are able to control them by a normal strength of will. We are all defective, both physically and mentally, and the perfectly normal individual has as yet not been born.

The impulsive obsessions and morbid and imperative impulses have been divided by REGIS into (1) the obsessions of indecision; (2) the obsessions of fear (phobias); (3) the irresistible propensities or morbid impulses.

OBSSESSIONS OF INDECISION:—The most typical of these is what has been called doubting insanity. It is often shown in a mild way by the patient questioning one's acts, such as an uncertainty that they have performed some simple thing, as locking a door, winding of the clock; as you may have heard Tristram Shandy

attributed all of his ill luck to the fact that at a very critical moment his mother exclaimed: "Mr. Shandy did you wind the clock?" and his father a second later remarking: "Damn the clock!" He claimed all of his doubts and ill luck hinged on the fact that his mother made the remark at a most inopportune time. This form most of us have to a greater or less extent and simply a manifestation of an obsession of doubt or indecision. The Germans have a name for another type called by them "Grubelsucht," or metaphysical mania. In this form the subject spends lots of time by distressing himself over some abstract or ridiculous questions: A young man had an obsession that he was about to lose his mind, and that led him to think of suicide, this to the question of immortality and whether there really was an hereafter and what would happen to him; a la Hamlet, To die, to sleep, to sleep, perchance to dream; ay there's the rub: (And the rub was enough to send him off on another subject upon which to vent his indecision.) Another is the constant starting to go some place and then go back time and again in order to see that nothing had been left, or that all was left as it should be and in this way probably miss their train, or car, if one were to be taken;. At times this is carried to such an extent that the patient will consume hours going up and down stairs; or from the yard to the house. Others again are bothered about the state of their souls and doubting if they have not committed some grievous sin and will hunt out some trivial affair and worry day and night about it; as some theft in early life. Others have an obsession that they must count the steps they take, and if by chance they forget the count they will go and count them over again; others step on cracks in the floor or walk and are very particular about it; others will count all the houses, posts or trees they may pass by. "In its severer manifestations this doubting psychosis may be a very serious matter; it may occur paroxysmally and be accompanied by precordial pains, headaches, etc. The common delusion of having committed the unpardonable sin in melancholics has some resemblance to some of the doubts and mistrusts, but the real melancholic is a different sort of case. These neurasthenic obsessions are not real delusions; the subject has a perfectly clear intellectual comprehension of his unreasonableness; they are simply ideas or feelings that he cannot get rid of at the time. It is in the milder manifestations, however, that these obsessions of indecision are most commonly observed, and in many cases they hardly affect the normal life of the individual, and to a slight extent they have been a part of the experience of very many otherwise mentally healthy in-

dividuals."

The Photobias or Obsessions of Fear. These are much less common than the obsessions of doubt and are manifestations of a more morbid and abnormal condition of mind. In these the patient suffers as much as though the fear was well founded. The mysophobia, or fear of dirt, causes the patient to put in great quantities of time in the endeavor to get rid of it; and he will wash and rewash his hands and face by the hour and still feel that he has not succeeded in eradicating the unseeable dirt; but to him the dirt is very manifest and visible. This mysophobia overlaps a little as it may be more of an obsession of doubt as to the presence of dirt in some of the milder cases. I suppose we have all experienced this phobia at some time or other, as for instance, after getting some bad odor on our hands and after washing several times the odor was still apparent; then, for fear some had been overlooked, we would again cleanse them with soap and water, only to have it still persist.

Obsessions of fear are a step further along and are more serious, if possible, than some of those we have mentioned; thus we have graphobia, fear of open places, patients cannot cross street or leave the fence on one side of the road to cross to the other; again we have the opposite of this claustrophobia where we have the same fear of narrow or inclosed places. Astrophobia fear of lightning; cremnophobia, fear of precipices; fear of blood, hematophobia, etc; all being some special form of phobia. Connected with these phobias we may have a type of morbid impulse such as the feeling that one has that they must throw themselves over a precipice, or off a tower, so that you see they all run into each other. People feel compelled at times to do things that their better judgment warns them against and after doing the act they have no good reason to offer for the commission of it. I have a young man that has the fear that he may sometime do some horrible murder in his own family, this originated when he was far from well upon reading of the Collins murder, supposed to have been done by the son of the murdered man; this made a bad impression on the young man's mind and he has worried over it a great deal for fear he may some day do the deed in spite of himself. I have had young lady patients that had the irresistible impulse to use profane and indecent language and they would give it full reign when in their own homes then would have a great mental dread that they would be guilty of the same language before strangers; or while on the street; or while visiting friends. This became so worrisome to one case that the

lady refused to go out or talk with people outside her own family. She had other marked manifestation of a disturbed mind and had to be treated for several months, becoming very much better and able to control herself.

The morbid impulse may take a ridiculous aspect at times as in the rhyme of Mark Twain: "Punch brother, punch, punch with care, punch in the presence of the passenjare;" one seems at times unable to rid the mind of the fool thing: presentiments come under this head and often worry the victim wonderfully. The morbid impulse to commit suicide from reading of others doing so; or beholding the body of a suicide, is often disastrous to those in a condition to take on the morbid condition necessary.

The sudden beholding of a gun, knife or ax, leads to attempts at homicide by certain neurasthenics and this fact should warn us to always keep such cases in a safe place while laboring under the conditions of mental upset. "Apparently different, but really closely allied, and belonging to the same general class of pathologic cerebrations, are the aboulias or the defects of the will, involving acts, where the patient has the desire, but not the power, to carry out the movement or purpose of his idea." (BB).

In many of these pronounced impulses and phobias have other neurasthenic symptoms; headache, digestive disturbances, insomnia, vertigo, paresthesias, etc. Probably not all of those that suffer from these obsessions are degenerates; still the majority of them are and it is often shown in the morbid craving for alcoholic beverages, a sort of dipsomania with a peculiar periodicity. A case well known to me was that of a very brilliant lawyer; he would describe his onsets of trouble in a very clear way—Taylor case. There is no social feature connected with these cases, they simply crave something stimulating and if whiskey is not available they will drink anything whatever, that has any alcohol in it, even red ink bayrum, etc. After the attack passes off, which may be in two or three days, or as many weeks, the drinking suddenly stops and great prostration follows and they have no excuse to make except that they simply could not help it, they cannot be prevailed to drink any more until the next attack occurs. This degenerative impulse occurs in other ways, as for instance a sudden desire for vagabondage; the patient will suddenly disappear and wander about the country as a tramp and keep at it for months at a time.

Probably a portion of the hobo element are old cases of morbid impulse and which has become a firmly fixed habit. Stamp collectors, coin collectors, relic hunters are in many instances only ex-

amples of morbid impulse. The clothing snipper, hair cutters, pin gatherers are all examples of morbid obsession propension. At times it takes periodical sexual perversion and men will do the most peculiar things at these times and at others seem to be quite normal in that respect.

Sexual perversion itself is to be reckoned among the degenerative borderland conditions; people that have the Fetish worship; sadist and masochists as well as those pederasts written of by Krafft Ebbing, are all samples of degeneracy with morbid impulse;. The killers for the sake of lust, as Jack the ripper, etc., are all carried away by uncontrollable impulse.

Kleptomania, pyromania, homicidal mania are all sad cases of the peculiar power that the morbid impulse has over its victim. All of the foregoing are without the least doubt a slight distance over the border and partake a great deal of psychopathy.

In most of the obsession of propension and morbid impulse there is a state of neurasthenia present which accentuates this and causes them to come within the psychical class of trouble. In the diagnosis of these states it is not so difficult to recognize them as it is to say how far do they go toward a condition of mental incapacity; if, as is the rule, they are accompanied, or rather intensified, by a neurasthenic condition; or are a result of some acute mental trouble; the question is how far are they, in a medical point of view, toward being troubles that ought to be cared for and orientiated from their fellows. No one doubts for a moment that those that have homicidal or suicidal tendencies should fall under some sort of restraint, but the question is should all of them be considered cases of psychoses and be treated as such. If we should take them all in, and have them cared for, I am afraid we would run short of proper attendants for their use.

The prognosis depends largely on the amount of original defect; the slight cases and those due to some enervating illness are deserving of favorable prognosis.

PELVIC PERITONITIS.**With Case to Illustrate.**

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Pelvic Peritonitis as the name implies, is a more or less localized inflammation of the general peritoneal cavity, which has been limited by the ever ready hand of nature so often manifest, in walling off rapidly extending virulent infections, in all tissues throughout the body mechanism.

In this skillful manner the other tissues of the body are protected from the intruding organisms, whose invasion if unchecked, would undoubtedly result in untold disaster to healthy functions of organs if not the dissolution of the entire body.

The exciting cause gynaecologically speaking is usually some localized virulent infection of the female genital tract.

As an illustration, the placental site of a puerperal uterus or the denuded surface after curettage of the endometrium for other localized conditions.

In the puerperal state the infection is usually implanted in suitable site and soil for rapid extension by the unclean hands of the accoucheur or the meddlesome douching or cleansing of the external genitals or the vaginal douche uncleanly administered by a well meaning lady friend or mother of the case, or perhaps as is sometimes the case, under the directions of the attending physician whose instructions are not carefully followed as to cleanliness of persons and instruments concerned.

The infection once implanted gradually extends by continuity of tissue to the muscular walls of the uterus from thence to the sub-peritoneal tissue and lastly to the peritoneum, where the reaction is very marked and the clinical picture quite plain.

Leaving this phase of the subject let us look for other sources of infection.

A septic endometrium produces a like condition in one or both tubes, inflammatory exudate gradually closes the proximal end of the tube and thus drainage is prevented and a localized abscess results, increased pressure soon forces a small quantity of infective material out through the Ostio Abdominale and thus infects the peritoneum; which because of the slow process usually limited in its spread by in-

flamatory exudate and adhesion and gives us usually a most typical attack of localized pelvic peritonitis.

A similar condition may arise but more violent in its onset where a distended pus tube suddenly ruptures and floods the peritoneal pouch with virulent pus, resulting oft times in a rapidly spreading peritoneal inflammation not allowing time for nature to limit the process by barriers of exudate and adhesions.

Pelvic peritonitis may follow pelvic cellulitis from the extension of the infection through the lymphatic space, or between the endothelial cells composing the tissues traversed. The ovary in these cases most usually suffers and an abscess usually follows.

A leakage of lochial discharge, a not uncommon occurrence, may give rise to severe localized pain and simulate a severe pelvic inflammation, but the effect is usually one of simple irritation and soon subsides.

In reciting the history of the following case the writers wish that a discussion will ensue from which we may all derive benefit and knowledge that will enable us to better deal with serious cases of like nature when encountered in our daily routine of practice.

Mrs. J. M. D. age 19 multipara, third child, confined October 13. Presentation L. O. A. Strong pains with rigid os, for which I gave chloral hydrat grs. 12 with positive effect and child was normally delivered after one hour and thirty minutes normal labor.

Was informed that if necessary to make a second visit I would be called, as they wished to save all expense possible.

Everything seemed to go nicely till Nov. 7, 1906, when I was hurriedly called out to the place in the country eight miles to find my patient suffering severe pain and vomiting, and was informed by her mother that some two hours previous to my arrival she had suffered from a severe chill beginning with pain which had steadily increased and a high fever was very evident from the general appearance of the patient.

My examination of the patient elicited the following data.:

Dorsal decubitus with knees drawn up; facies anxious extreme, respiration shallow and irregular, pulse 120, temperature 104ss, skin dry and harsh, eyes sunken, great thirst, bowels were moving or attempts were made to defecate every few minutes with small liquid stools. vomitus grass green with mucous, mentality clear but expression was that of extreme suffering. The entire abdomen extremely sensitive to the slightest touch, tenderness increasing from above downward, entire abdominal wall fixed, rigidity more marked below umbilicus and to the left of the median line internal to the anterior superior spine of the left Iliac bone. Percussion tympanitic over the entire abdomen.

Questions as to nature of lochia following confinement was negative. But the statement was then made that a blood stained mucous discharge still continued but was free from the slightest odor or did not look badly,

the amount was small at this time, not requiring a pad for its collection.

Examination of the vulva showed nothing abnormal, perineum free from recent lacerations but showing a partial rupture from some previous confinement which had not been repaired.

Bimanual examination poorly executed because of rigidity of abdomen showed a large uterus throughout and pressure on the cervix caused severe pain. Cervix lacerated unilateral, and to the touch the borders of the torn area seemed to be rough, Os would not admit finger. Would simply state here that the uterus while not freely movable was in no wise rigidly fixed as we sometimes find it in some inflammatory states of the pelvis.

Speculum examination simply confirmed digital manipulation, the vagina was markedly congested, cervix at site of old laceration was eroded but not badly. From the external os there was escaping a mucous discharge occasionally streaked with quite red blood.

Cotton on applicator convinced me that the trouble or site of infection was higher in the endometrium.

Diagnosis: Pelvic Peritonitis resulting from a septic endometritis and transmitted to the peritoneum through the left tube.

Cause probably to the douching of the vagina by the mother with an unclean syringe and water that had not been rendered free from contaminating material.

In conclusion of the recital of the above case, would say that the patient sat up the tenth day following confinement and a few days following would assist with light duties about the house, but seemed that regaining strength was somewhat slower than usual.

Nov. 6th patient came to town with the family, remarking on the way how well she was feeling, and the above described condition came on suddenly the morning of the 7th, the following day.

TREATMENT OF ABOVE CASE.

A hypodermic of Morphine Sulphate $\frac{1}{4}$ grain was immediately given with partial relief from pain followed in 30 minutes with $\frac{1}{8}$ grain of Morphine with Atropine.

A vaginal Creolin douche was then given 10 per cent. and patient was elevated to an incline by use of pillows and directed to lie quietly and not be raised for urination or defecation, and no food to be taken till directed.

Tablets of morphine sulphate $\frac{1}{8}$ grain were then left with directions to give one every two or three hours as needed to control pain.

Told the family I would return the following day with Dr. Howell and would clean out the uterus which I thought was the primary source of infection.

The afternoon of Nov. 8th found patient resting easier but had required morphine about every three hours to control pain. Tenderness somewhat diffuse still but extreme below a line from anterior superior spines, bowels had moved and patient had urinated satisfactorily.

Temperature 102, pulse not so small but still quite rapid, 120, expression but little changed although not indicative of so extreme suffering.

Patient was then anesthetized by Dr. Howell and after shaving, scrubbing and creolin douche the lower lip of cervix was grasped by means of a vulcella not rapidly and forcibly drawn down as is often done but simply

held firmly in a position to admit the dilator which was used to dilate cervix sufficiently to admit the index finger for the purpose of determining the condition of the uterine cavity, the walls seemed normal until the posterior wall high up in the fundus was reached, the finger then detected quite a mass of what felt like adherent placental tissue, which was carefully removed by means of a dull curette.

The detached material had the appearance of a large mass of fungus granulation tissue, clean, free from putrefaction and apparently well supplied with blood from the free oozing of bright red blood.

After again carefully examining the walls of the uterine cavity and determining the complete removal of the mass, a creolin intra uterine douche was then given by means of a douche bag and a reflux irrigator until the return flow became entirely free from loose tissue.

A firm sterile gauze packing of uterus and vagina followed a sterile vulvar pad applied and held in position by a T bandage and patient returned to bed in good condition.

Morphine sulphate 3-16 of a grain was soon administered by Dr. Howell hypodermatically.

Directions were then given as were necessary to prevent nausea following the anaesthetic, and we left the patient in an apparently satisfactory condition until our return the following day.

I returned the following evening to find the patient in practically the same condition as before the operative work. Temperature 102 but had varied during the night and following morning, pulse somewhat better, fuller and not so rapid as the previous evening.

Abdomen still extremely tender, but a distinct pelvic localization could now be determined with greatest induration on left of median line.

Vaginal and uterine pack removed causing considerable pain after which a hot vaginal douche was given and emplastrum Sinapis applied to lower abdomen until well reddened.

The morphine was directed to be withheld as much as possible and a saline cathartic to be administered the following morning. Nov. 10th.

Nourishment was limited to small quantities of broth or egg-nogg at intervals of three hours; water to satisfy was allowed. With these directions the patient was left to await the next visit on the following day.

Patient showed little change until after midnight on the morning of Nov. 10th, when she became more restless and suffered another chill. I was hastily sent for and on my arrival found an exacerbation of all primary symptoms. Temperature 105, pulse again rapid and wirey and patient suffering, respiration again rapid and irregular, nausea but had not vomited.

Severe pain on the right side but the general tenderness was not so marked as in the beginning. Bowels were moved as directed by saline followed by an enema a creolin intra uterine douche was then given and the opiate still continued.

Considerable pain was caused by speculum introduction from its contact with the uterus. The vaginal examination at this time showed some fullness in pouch of Douglass which was quite tender to pressure.

Quinine sulphate was then directed to be given 3 grs. every three hours till my return that evening.

Upon my return that evening, Nov. 10th, found temperature 102 1-5, pulse 108, better quality, pain not so continuously severe, abdomen still tympanitic with greatest tenderness below umbilicus, vaginal discharge nil.

Digital examination of vagina showed increased fullness in pouch, per rectum showed greater bulging in rectum from right, and tender to pressure.

Patient's condition on the 11th showed slight improvement in general condition, pulse and temperature. Temperature had varied during the night and following morning, varying from 101 to 103.

Several attempts to defecate caused pain and was described by the patient as though something filled the rectum and prevented a passage. Digital examination showed increased fullness of pouch and rectal bulging, no fluctuation, however.

Quinine and opiate had been continued; the morphine intervals of dose increased, being given only at intervals of about five hours.

Nov. 12th patient's condition practically unchanged, temperature still varying and pulse unchanged, the tongue, however, showed extensive coating with red borders and soreness of the mouth and tongue complained of.

Tenderness of abdomen above umbilicus considerably lessened below the rigidity quite extreme, but tenderness not so great. Bowels had moved satisfactorily, but some trouble was experienced with urine being obliged to urinate quite often and small quantity each time. Examination showed bladder $\frac{2}{3}$ full, catheter used and quite a quantity of normal looking urine procured, with relief of distress.

Nov. 13th patient had a fairly good night and complained of being hungry, general condition somewhat improved, tongue showing signs of clearing, and patient resting better with less morphine to relieve pain, which was now more spasmodic in character and on the left side above the left iliac crest. The culdesac was full and the rectal bulging extreme, feeling quite hard and free from fluctuation.

Left patient on this occasion with the idea of returning the following day to establish vaginal drainage.

Nov. 14th patient had spent the best night of all, had taken egg-nogg every three or four hours, and had slept well the greater part of the night.

Pulse 98 and good quality, temperature had remained lower only once registering 103 during the night, abdomen soft above the umbilicus and much less tender below, tympanites disappearing and tongue rapidly clearing, patient catheterized a vaginal douche given and the vagina and rectum again examined. No change could be detected in previous conditions found and drainage was deferred.

The morphine and quinine were withdrawn and in their stead a mild laxative was prescribed and the following tonic reconstructive given: Syrup of the iodide of iron fluid drachms 4, syrup of hypophosphites comp. Fellows, sufficient to make fluid ounces 4, a teaspoonful to be taken in water every three hours till further directed.

Nourishment to be only egg nogg, broth or soft egg every three hours if seeming to agree.

It was impossible for me to make a call on the two succeeding days, the 15th and 16th, but was informed by telephone that the condition of the patient seemed better.

Early the morning of the 17th I was agreeably surprised to find the gen-

eral appearance of the lady so much improved. Temperature had been running lower, the pulse getting better, the tongue was still coated but showed marked signs of clearing, bowels had been moving quite well and appetite improved. Was surprised when a vaginal examination was made to find the filled culdesac smaller without signs of suppuration, and the rectal bulging showed even greater reduction.

Nov. 19th improvement continues, temperature varies between 100 and 101, pulse still improving.

Nov. 20th improvement marked, abdomen soft, free from gas. The only induration being low in the pelvis.

Nov. 20th. The culdesac still a little indurated but bulging was slight indeed, rectum almost normal. Temperature had been normal most of time and no pain except on deep pressure over site of both ovaries and tubes.

Patient was convalescing rapidly and resolution going on nicely.

Some of questions which came to me while reviewing this case were these:

What methods are we to employ clinically in determining the primary site of infection?

2nd. When found what are latest and best method of dealing with the local condition, taking into consideration assistants, surroundings, etc?

3rd. Methods of determining positive indications for vaginal drainage?

4th. When is abdominal section indicated and when contra indicated?

5th. Technic and possible dangers in establishing vaginal drainage?

6th. Site of operation technic and possible dangers in abdominal section?

7th. Should general practitioners resort to surgical means in dealing with cases of this nature or should they immediately be referred to a surgeon for further care?

In briefly considering No. 1. Prosupposing a thorough knowledge of pelvic structures and their relation one to another:

The prime essential is a thorough and systematic examination of the entire birth canal and the pelvic contents, especially the tubes, and include in the above the appendical region.

No. 2. Mechanical means should be carefully resorted to, particular precaution should be exercised to avoid opening up new avenues for the absorption of infective material.

Only antiseptics which have the greatest germicidal power with least inhibitive action on regeneration of tissues should be used.

If a distended pus tube exists immediate laparotomy should be resorted to, followed by thorough drainage.

Of course to carry out the last named procedure successfully, trustworthy assistants are necessary, as is also proper instruments and a thorough working knowledge of asepsis.

The immediate surroundings need not cause hesitancy when your duty to your patient is plain, as oft times the greatest surgical successes are envired by conditions most intolerable.

No. 3. Pulse and temperature range with careful palpation of the cul de sac both per rectum and vagina. If a boggy tumefaction is evident with general conditions indicative of purulent accumulation immediate exploration with an aspirator is undoubtedly indicated, if pus is found im-

mediate drainage should be instituted.

In considering No. 4, broadly speaking, abdominal section is only indicated when the pus accumulation is not readily accessible from vaginal route; that is when the accumulation is latterly situated, is high up in the pelvis as is often the case.

Accumulations latterly situated sometimes appear to be readily accessible to operative work but the danger of wounding the uterine artery or the ureter on the side of operation should never be considered lightly, as embarrassing accidents have often occurred in the experience of skilled operators.

In dealing with No. 5 we find a difference of opinion existing among different operators as to the exact method of obtaining the same end, not so much in choice of site for the attack but more as to the methods of incising, the instruments used, etc. One operator will advocate the longitudinal incision approaching the bulging sac by carefully dissecting his way through the everlying tissues and ligating bleeders as he proceeds.

Most operators, however, consider the transverse incision preferable, incising the vaginal wall about one-fourth inch below the cervix vaginal junction, first because of hemorrhage, which is often quite troublesome, and because of the poor accessibility of the parts is difficult to control.

Second, because of the scar being cut reach of irritation and in the direction of the normal rugae of the vagina.

The operation is then completed by means of a sharp pointed scissors or forceps which is thrust through the remaining tissues into the culdesac and the blades being widely separated are withdrawn thus giving a free opening into the pus sac.

The application of proper drainage which usually consists of a double rubber drain, in order to facilitate irrigating the cavity.

Others insist that no instrument be used except the thermo or electric cautery in establishing a vaginal drain which does away with hemorrhage practically and also forms a barrier to absorption of septic material from the incised wound borders.

The only dangers encountered in the above procedure are the accidental wounding of a ureter or the severing of the uterine artery which if occurring gives free bleeding and in a locality where the securing of the severed artery is a tedious undertaking.

Free bleeding from the smaller branches often occurs, causing loss of time and delay in completing the work of drainage.

Only a few words relative to No. 6. The site of operative attack is always determined by the accessibility of the object of operative interference modified by the resultant risk accruing therefrom in any given case.

The technique employed will of necessity be wholly governed by the site of operation and the work to be accomplished in any given case.

The danger attending abdominal section for virulent infection of pelvic origin is principally that of general peritonitis due to contamination of the general peritoneum in the necessary manipulations incident to the operative work, in other words breaking up adhesions that nature has intended to protect and guard against the further spread of the detrimental infective material.

Relative to No. 7. None of us or the general public should attempt to judge of a man's ability in dealing with grave conditions in medicine or

surgery even though he be a rural practitioner But he, himself, must be the one to choose, and if finding himself conscious of his ability to attempt the undertaking with the necessary assistants at hand he should always do the work himself as nothing is ever gained by curbing one's opportunities

ETHICS.

J. H. BOSWELL, M. D., Baxter Springs, Kan.

Would that I possessed the qualifications to adequately present this subject for your worthy consideration. Its full conception is vast and full of significance, being based principally on the GOLDEN RULE, so impossible to live up to although our conduct is apparently ideal.

This is a subject whose principles were founded centuries ago. Ages have not added to its scope and very little has been done to supplement the OATH, formulated by the IMMORTAL HIPPOCRATES to apply to our profession. The OATH so broad and containing of honor and goodness so much that one who desires to live up to and practice its teachings must be a MAN in the fullest sense of the word. He must possess all the qualities of a gentleman, the knowledge of a scholar and a never ceasing activity.

For the purpose of discussion I will divide this subject into two grand divisions. First, the duty of the physician to his fellow men. Second, the cultivation of brotherhood and equality in the profession as we cooperate and study for the advancement of our art and science.

To do our very best for our fellow men requires that we be properly fitted and amply equipped for a life's work. We should go into it with the idea that we are fulfilling a mission, that the world will be benefitted by our having lived in it.

The duties of a physician are complicated, embracing his relation to the individual, the victim of disease under his care, and a wide public sphere, his relation to the general health of the community in which he lives. These require that he exercise the highest functions of his intellect and heart to properly perform them, which can be brought about only by a careful and rigid education, for he must not only have technical skill and capacity but he must have a sympathy and interest in all pertaining to man and his environment. There is now a great movement taking place over the

world to raise the standard of medical education. Most of the states have realized that it is proper to safe guard its citizens from physicians whose training has been such as to preclude all possibility of their having a competent knowledge of medicine as well as from quacks and charlatans and are making some progress in this direction by raising the requirements for permission to practice in their state.

This progress may seem to us very slow but by looking back a quarter of a century and comparing conditions that existed then with those as we have them at the present time we can see that a great revolution has taken place. If this advancement goes on at a proportionately rapid pace for the next twenty-five years the degree of Doctor of Medicine will command respect which is too often, and in many cases justly lacking at present.

To do our best for the community we should each be a factor in waging the campaign of popular education which is being so beautifully carried out by the press at this time. Superstition and mystery always have been and are still an impediment to the proper practice of medicine. If it were not for them what would the patient medicine man do with all his discoveries and cures? Too many doctors think that good advice consists in finding out what the patient wants you to tell him, and then advising him accordingly. Why not be honest and tell him that you do not know, when you do not, then it may be some time afterward when you give him an opinion he will have faith in you, for he has reason to believe that you are on the square. Our profession does not command the confidence and respect that it should.

For the promotion of good fellowship and harmony among ourselves nothing is so essential as being an active member in one's local medical society. It is with this idea in mind that N. S. Davis, Sr. devoted most of his time for twenty years in organizing and supporting our National Association. When one so great as he thought it wisdom to give up almost one-half of his active life for this worthy cause it does seem strange to think that there are practitioners who will not walk through the door of their own county society when it is left ajar for them.

In it we get acquainted. In it we meet our competitors and before we part we are colleagues. Old jealousies are dissipated and we become mutual friends. By this we learn more to respect each other and by so doing command the confidence and respect of the community at large. We will learn to know each other as brothers,

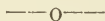
as co-workers in a common cause, and when we need consultation we will not hesitate to call in these co-workers.

Whenever a doctor habitually ignores his fellow practitioners in the same town and sends to larger places for counsel there is usually something wrong somewhere. Either he is not a member of the medical society himself or it is because his fellow practitioners are not.

When this state of affairs can be so adjusted that every practicing physician will be an active member in his county society, mutual destruction, strife and jealousy will give way to fraternal trust and good will. No factor contributes more to the success of the unethical than the lack of unity of purpose and professional dignity which prevails at the present time.

Make the practice of medicine a profession and not a trade, an occupation on a high plane where only those who are properly fitted may enter for their life's work and become co-operators with their colleagues.

Trade knows only the ethics of success. Profession is bound by the lasting ties of sacred honor.



NEWS AND NOTES.

With the April issue of The Journal Dr. Geo. H. Hoxie, dean of the School of Medicine of the Kansas University, severs his connection as editor of The Journal of the Kansas Medical Society. He was elected editor in May 1903, and since taking charge he has devoted much time and thought to work connected with the Journal, and it is now recognized as one of the best state society journals published in the United States. He is a keen, critical observer of all that pertains to the medical profession, and gave to the Journal only that which was BEST, and would stand the test of close scrutiny. The medical profession of Kansas will always owe a debt of gratitude to him for his earnest work in organizing the profession of the state and elevating The Journal to its present high standard.

The editor-elect, on assuming the responsible position of editing The Journal for the next year, asks the help and co-operation of all the membership. By the friendly help from the component county societies, and hard work on his part, he will endeavor to keep The Journal on the high plane to which Dr. Hoxie has raised it.

Pneumonia

The three great points in pneumonia are to relieve congestion, maintain intestinal activity and cleanliness and improve metabolism. Systemic antiseptics are also indicated. The man who used calcium sulphide, aconitine, veratrine and digitalin (Abbott's "Defervescent compound") the sulphocarbolates and nuclein CURES his cases, frequently aborting them within a few days. "Clinical Medicine."

Diphtheria—Diphtheria is pre-eminently a local infection followed by severe systemic disturbance from the absorption of toxins generated by the bacteria in the local column. The modern therapist treats condition present, never diphtheria as such. The bowels should be emptied and the liver stimulated and intestinal antiseptics maintained with the sulphocarbolates. Fever, if this is done promptly, yields to a few doses of aconitine, strychnine and digitalin. Nuclein should be given to stimulate phagocytic activity, the throat sprayed with peroxide of hydrogen and aqua cinnamoni, and calcium sulphide and calx iodata (Calcidin Abbott) pushed to effect. The necessity for perfect cleanliness of nares, fauces and buccal cavity is apparent. In profound septic conditions, echinacea has been found to be of signal service.

Letter from Board of Control.

Editor of Journal of Kansas Medical Society:

In an editorial in your March number of The Journal you say, "Dr. Kuhn, superintendent of the Farmington, Missouri, asylum for the insane, appeared before the Jackson county medical society and demonstrated a remarkable similarity in the blood analysis of patients suffering from insanity to that of patients suffering from auto-intoxication and toxæmia. And that Dr. Kuhn believes that the present method of conducting state institutions for the insane, is simply a matter of running a boarding house for them, and making them comfortable; and as far as scientific medicine is concerned, nothing is being done outside of the states of Illinois, Ohio and Massachusetts. And he says there is no demand whatever for scientific treatment, and therefore the superintendents of the institutions are simply farmers, engineers, or boarding house keepers." And you say you have a great deal of sympathy for Dr. Kuhn's contentions, and suggest as a remedy that a hospital for the insane be put in charge of the State University. We know nothing of the

Farmington, Missouri, asylum, but we do know that this article is a flagrant misrepresentation of the Kansas State Hospitals. The superintendents of the Kansas institutions are without exception men who have long been prominent members of their profession. One of our superintendents is now president of the Kansas State Medical Society. Each superintendent has a staff of competent medical men, possessing skill and experience. Among these are surgeons, gynaecologists, bacteriologists, and pathologists, who give their patients the best treatment known to modern medicine. When patients are received into our hospitals they are placed in an environment that reduces the mental stress. An effort is made to cure them of every bodily ailment. Our patients received the benefits of surgery, electric therapeutics, internal medicine, hot and cold baths. The baneful effects of auto-toxaemia, mentioned in your article as something new, has long been known to our hospital physicians. Nearly all the cases of mania, melancholia, and primary dementia, present symptoms of toxaemia due to scanty secretion, and suspended elimination. Our physicians endeavor to remove this condition by means of medicines, electricity, hot baths, etc.

During the last two years the surgical and plastic gynaecological work done in our institutions would have cost those patients more than thirty thousand dollars. Is not this a little better than ordinary boarding house care? Our hospital physicians are utilizing the latest discoveries of scientific medicine. When admitted a chemical and microscopic examination is made of the blood and urine, and the revelations thus made, in conjunction with the clinical history, enables our physicians to make a positive diagnosis, and prescribe intelligently. The patients are individualized, and each is faithfully treated until recovery occurs, or the disease is pronounced chronic and incurable. In each institution where acute cases are treated the medical staff is assisted by a corps of trained nurses.

We have at hand the latest reports from the states mentioned (Ohio, Illinois and Massachusetts), and taking the average number of patients discharged restored from their institutions in comparison with the number discharged restored from the Kansas State Hospitals for the same period, we find that the Kansas institutions do not suffer in the least by the comparison. The people of Kansas have been most liberal in the expenditure of money to build up the state hospitals, and it is the earnest desire of the members of the board of control, the superintendents and the medical staffs of these

institutions that they be brought up to the highest possible degree of efficiency, and we are sparing neither labor nor money to bring about the desired end.

SHERMAN G. ELLIOTT.

Lay Medicine.—The Kansas City Times for April 5, 1907, contributes the following to the history of medicine:

London, April 5—Sir Joseph Lister, the surgeon, and Algernon Charles Swinburne, the poet, are celebrating respectively their eightieth and seventieth birth anniversaries to-day. Both are in excellent health.

Sir Joseph Lister is the inventor, compounder and discoverer of listerine, the antiseptic. He was made a member of the nobility in 1883, by Queen Victoria in recognition of his work for science. Swinburne is one of the most widely known of present day English poets.

The Lambart Pharmacal Co. might profitably use this clipping for a general advertisement.

The American Academy of Medicine will meet at Hotel Dennis, Atlantic City, on Saturday, June 1st and Monday, June 3, 1907.

The Santa Fe Ry. has offered reduced rates and splendid service for the meeting of the American Medical Association at Atlantic City.

Press reports sent out from Washington April 18, say that the same influences and organizations which caused the passage of the Pure Food Bill have started a movement for the creation of a new governmental department to be called the Department of Public Health. The plan is to enlarge the cabinet by creating the above named position. This is a step in the right direction. There is nothing more important than the proper execution of the various statutes which concern the public health. This would place the administration of the Pure Food Law, meat inspection, quarantine regulations, including the present public health and marine hospital service, and all regulations as to health which has to do with the admittance of immigrants to this country, under this department. At present the various duties, relating to public health are divided among the treasury, the agricultural, the commerce and labor and the war departments. The head of the proposed new department being a cabinet officer and a medical man, would be a proper recognition of the medical profession. Every state society should co-operate with the American Medical Association in pushing this movement.

Dr. M. F. Jarrett of Ft. Scott was appointed by Dr. Uhles, president of the State Society, a delegate to the Council of Medical Education, which held its Third Annual Conference at the Auditorium Hotel, Chicago, Monday, April, 1907.

Theodore D. Buhl, president of the Parke, Davis & Co. Drug house, died April 7, 1907. Below is a copy of memoriam adopted by the Board of Directors on behalf of the stockholders:

Ten and a half years ago Theodore D. Buhl cast in his lot with this house. Throughout that period he has given us the benefit of his large experience, his sound judgment, his great power in the commercial world, his granite credit reared on an unwavering honesty. As president of the house he was the perfect type of integrity and fidelity to all the stockholders. His high sense of duty as a trustee pledged to administer the property and guard the interests of others, was ever uppermost in his thoughts. The peculiar responsibilities and hazards of our work—our obligations as purveyors to the medical profession and to suffering humanity, were to him always a solemn appeal. The ultimate triumph of character in business was with him a conviction as deep and strong as instinct. The remote future and the distant prize concerned him more than the present gain.

The strength which he gave this house and all the many enterprises in which he shared, signally exhibits what the world should realize especially at this hour—that rich men of unflinching honesty and sound judgment are of inestimable value to their communities. They are the employers of labor, the authors of new industries, the creators of new values, the pioneers who open up vast avenues of opportunity for their followers. As they succeed or fail, the comfort, the very bread, of thousands is assured or endangered. We hear much these days of unscrupulous, predaceous wealth, but what of the type of Theodore Buhl—what of the men who consider the trust of their fellowmen the best of their possessions, who have a horror of stock-jobbing methods, who never seek an unfair advantage, who never lend their names to a dubious enterprise?

As a director Mr. Buhl was the soul of courtesy, kindness and deference. As an employer he was considerate, thoughtful, mindful of the comfort, interests and claims of his employees. To their grievances he gave always a patient and attentive ear. He encouraged the manly expression of honest opinion, and when it differed from his own his effort was to convince and persuade, not to invoke his authority or impose his will.

On behalf of the stockholders, employes and executives of Parke, Davis & Company we record this testimony to the lasting service rendered us by our lamented president. To the members of the bereaved family we offer our heartfelt sympathy. May strength be theirs to bear their sorrow. May they find much comfort in the memory of a life rich in well-doing and in good repute.

Smallpox.—In the December 21, 1906 report of the Public Health by our federal government Kansas is credited with 592

cases of smallpox with one death. During the same period in 1905 we had 406 cases with four deaths. During the entire year 1905 there were 4116 cases and 33 deaths. New York state with its immense population had instead of 592 only 333, and instead of 406, only .8. The Middle West evidently needs some education along the line of public health and vaccination. Evidently also we in Kansas have much to fear from such fool discussions as Elbert Hubbard is guilty of.—G. H. H.

A physician in a good town in east central Kansas writes us that he is going to take up a specialty and desires to sell his office and equipment of electrical and mechanical outfit. A good location in a large territory. He will give a more complete description by correspondence. Address all inquiries to E. L. Mulliken, Columbus, Kan.

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SOCIETY NEWS.

Dr. G. H. Hoxie, Rosedale, Kan.

Dear Doctor:—The Wilson County Medical Society met at the court house at Fredonia at 1:30 p. m. the second Tuesday of this month, that being the time for our regular meeting.

Called to order by President Preston of Buffalo. Reading of minutes of December meeting, there having been no meeting in February account no quorum.

Report of outgoing secretary and treasurer, Dr. E. N. Martin, approved. A paper by Dr. Martin on Sciatica was well taken and freely discussed. Paper by Dr. Sharpe of Neodesha on Neuralgias elicited general discussion.

Dr. A. H. Rogers of Altoona was appointed to read a paper at our state meeting in Kansas City, and selected "Diseases of the Eye as seen by the General Practitioner." I communicated with the state secretary but it was too late for Dr. Rogers' paper to be entered on the program.

Dr. W. H. McConnell of LaFontaine having applied for membership, was duly elected. We are particularly glad that Dr. McConnell has taken membership with us, being well and favorably known, and not having taken his stand with us since our last organization. Dr. J. C. Hodges who lately located in Altoona, also became a member at this meeting.

We hope to send you a corrected list of our members at an early date for publication in the State Journal.

Those present were: Dr. E. N. Martin, Benedict; Dr. J. C. Preston, Buffalo; Dr. W. H. Addington, Altoona; Dr. L. L. Jones, Altoona; Dr. A. H. Rogers, Altoona; Dr. O. D. Sharpe, Neodesha; Drs. A. C. Flack and E. C. Duncan, Fredonia.

Adjourned to meet at Neodesha at 7:30 p. m. second Tuesday in June. Farternally, E. C. DUNCAN. Secretary.

The Southeast District Branch of the Kansas Medical Society met at Fort Scott April 2, 1907.

The attendance was large and much interest taken in the meeting. L. R. Sellers of Osawatomie read a paper on "Plastic Gynaecology in Insane." The writer advocated an examination of all insane women for injury to peritoneum and crevix and an early operation.

Dr. A. H. Cordier of Kansas City presented a paper on "Operation for Hernia", which was discussed by all present.

Dr. M. F. Jarrett of Ft. Scott presented an eye clinic. The case was an old man 87—cataract of both eyes. The result of operation gave the patient fair vision, he being now able to take care of himself.

Dr. E. E. Leggett of Oswego was re-elected president and Dr. A. J. Roberts of Ft. Scott secretary for the ensuing year. Doctors Honawalt, Jackson, Cordier, Frankenberger of Kansas City were present.

Parsons was selected as the next place of meeting.

The April meeting of the Western Kansas Medical Society was held at Oakley. The attendance was poor, only two of those on the program presenting their papers. Nevertheless the meeting was thoroughly enjoyed by those in attendance. Those present were: Drs. Lake, Lowis., Miller, Carmichael, Winslow, Gulick and Stoner.

The visiting doctors were entertained at luncheon at the home of Dr. Winslow. The subject of all papers were discussed at length, and Colby was decided upon as the next place of meeting July 10th.

F. A. Carmichael, Secretary.

Sumner County Medical Society.—The Sumner County Medical Society held its annual meeting in the Commercial club rooms last evening and later had a banquet at the New Arlington. The officers elected for the ensuing year are Dr. F. M. Owens of Argonia, president; Dr. Melvin Collins of Oxford, vice-president; Drs. W. S.

Bartlett of Belle Plaine, E. A. Evans of Conway Springs and J. M. Hunt of Wellington, censors; Dr. T. H. Jamieson of Wellington, secretary and treasurer; Dr. W. H. Neel of Anson, delegate to the state association.

The banquet was quite an elaborate and lengthy affair. The new president, Dr. Owens, acted as toastmaster and Drs. Shelley, Martin, Rea and Neel responded to toasts. The guests at the banquet were: Dr. J. M. Hunt, the retiring president, his wife and daughter, Dr. F. M. Owens, wife and daughter, Drs. T. H. Jamieson, F. G. Emerson, S. W. Spitler, L. F. Harmon, J. A. Rea, W. M. Martin and L. S. Copeland of this city and their wives, Dr. R. H. Downing and wife of Corbin, Dr. G. L. Millington and wife of Oxford, W. G. Moodie and wife, Miss Clara Halliday and Miss Bea Emerson of this city, Drs. Melvin Collins, of Oxford, E. A. Evans of Conway Springs, W. H. Neel of Anson, H. L. Cobean and W. H. Rea of this city.

The banquet and program were both thoroughly enjoyed until a late hour.

The annual meeting of the Golden Belt Medical Society took place at Abilene, Kansas, April 4. The following officers were elected: President, Dr. Howard N. Moses, Salina; vice-president, Dr. D. E. Esterly, Topeka; secretary, Dr. W. S. Yates, Junction City; treasurer, Dr. J. D. Riddell, Enterprise; librarian, Dr. Edw. E. Hazlett, Abilene. The society decided to make the library a permanent feature of the organization in the collection of standard periodicals and medical works of a historical nature. Headquarters for the library will be at Abilene. The meeting places for the ensuing year are: July 11, Junction City; Oct. 3, Salina; Jan. 2, Manhattan; April, Abilene.

The Brown County Medical Society met in regular quarterly session Tuesday, April 4th. The attendance was not what it should have been but the interest was keen and the afternoon seemed profitable to all present. Dr. W. W. Nye presented the subject of Uterine Inertia with a paper. Dr. R. L. Funk read a paper upon Morphine-Hyescine-Cactin-Anaesthesia. Drs. J. J. Komer and L. Reynolds gave us the benefit of their experience with automobiles in country practice.

L. W. Shannon, Secretary.

Report Marion County Medical Society, April 10, 1907. Meeting held in Peabody. Meeting called to order by President Dr. Grant

Myers. Papers were read by Dr. O. J. Furst of Peabody on Impacted Cerumen and by Dr. R. C. Smith of Marion on Infant Care and Feeding. Papers were discussed by the members of the society. The next meeting will be held at Marion July 10.

H. M. Mayer, Secretary.

At a meeting of the Pratt County Medical Society held April 1, 1907, the following resolutions were unanimously adopted:

That the following preamble and resolutions are adopted by this society in session at Pratt, Kan.

Whereas. Many of the life insurance companies have notified their medical examiners of reduction of examining fee from \$5.00 to \$3.00, and

Whereas. We, as physicians, realizing the responsibility incident to proper examination of the individual, believes such reduction to be unjust, therefore be it

Resolved, That the Pratt County Medical Society, and the medical profession in sympathy with them, in session assembled, do hereby declare such reduction to be unjust, and respectfully request that no physician legally authorized to practice medicine in Kansas accept such reduction of fee; and further that any physician accepting such reduction be guilty of a breach of professional courtesy.

Resolved, That it is the sense of this society that hereafter in each examination for life insurance in which urine analysis is required the minimum fee shall be \$5.00.

Second. That the above rates shall not apply to industrial medical inspection, without urinary analysis, for amounts less than \$1,000.

Third. That no member of this Society enter into any contract or agreement with any corporation, society, association, company or individual to examine applicants for insurance for any stated salary or lump sum, thereby evading the spirit and instinct of the foregoing resolutions.

Fourth. That the payment of all fees shall be authorized by the home office of the society or corporation to which such application is made, and under no circumstances shall an examiner receive or accept any part of this fee from an agent or any other person or corporation, unless the full fee be paid by authority of the home office.

Fifth. That each member of this society pledge himself or herself, in case a fellow member be removed from the position of examiner for any corporation or society solely because of this action of the medical profession, that he or she will not accept an appointment from such corporation or society as examiner, nor make any examination for same in Kansas.

Sixth. That each member of this Society bind himself or herself, by a pledge to be presented by him or her to the secretary to abide by these resolutions.

ATHOL COCHRAN, Secretary.

Editor Journal, Columbus, Kansas.

My Dear Doctor:—The Cherokee County Medical Society had

one of the best meetings in its history on Tuesday evening April 9th at Galena. Dr. J. P. Scoles presented a case of tubercular hip-joint disease of about forty years standing which proved very interesting to all present. Dr. J H Boswell read an excellent paper on Ethics, the discussion of which occupied the greater portion of the evening. Dr. M. L. Perry, Supt. of the State Hospital for Epileptics at Parsons, Kan., was to have read a paper on The Early Recognition of Epilepsy, but owing to the sudden and severe illness of a child he was unable to be present. This proved quite a disappointment to us, however the discussion of the subjects presented occupied our time until a late hour, when refreshments were served, which concluded the program.

About twenty of the members of the Jasper County, Missouri, Society responded to our invitation to meet with us and their presence added much to the enjoyment of the evening.

We will hold our May meeting on the third Tuesday to avoid conflicting with the meeting of the State Society.

Very truly, R. Claude Lowdermilk, Secretary.

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ABSTRACTS.

Digitalin in Angina Pectoris.—Fiessinger (Journ. des Praticiens; Paris Med. Journ. March), from a consideration of the possibility of there being cardiac distention in cases of true angina pectoris, has treated patients affected with this trouble with small doses of digitalin, and in many cases with very great benefit. Since in these patients arterial tension is frequently high, and is still further heightened during the paroxysms, only small doses of digitalin should be given; and to combat the high arterial tension theobromine may simultaneously be given. The author advises that five drops of a 1 in 1,000 solution of crystalized digitalin be given daily, and that 0.5 gramme of theobromine be administered before the mid-day and evening meals. After ten days the digitalin should be stopped, to be resumed after ten or fifteen days. This treatment is not always successful, but appears to have its best effects in those cases of angina in which, between the attacks, the patients suffer from dyspnoea on exertion. Patients should be very abstemious as regards eating and drinking. If fat, suitable treatment should be carried out to reduce the excess of adipose tissue; and by these means the author has been able to obtain "cures" in men of seventy years or upwards.

The Diagnosis and Treatment of Malaria.—D. Vander Hoof, Richond, Va. (Journal A. M. A., April 20), insists on the importance of blood examinations and especially of fresh blood in the diagnosis of malaria. If stained specimens are used care must be taken not to confuse the platelets, which are usually numerous in malaria, with the parasites, especially when they are superimposed on red blood cells or are gathered into clumps resembling somewhat a segmenting form. When the parasites are very few the Ross method of using very thick smears and after drying, dissolving out the hemoglobiin and then using the ordinary staining and fixing methods may be used. The crescents of the estivoautumnal type then stand out prominently, but the smaller forms are liable to be lost in the mass. The best time to study the blood is just before a chill, as it then contains the adult pigmented forms that are most easily recognized. The leucocytic count in malaria fever shows a normal or decreased number of these cells and this is an important point in diagnosis as it serves at once to distinguish it from some other conditions associated with a remittent or intermittent temperature cure. The differential count is also often suggestive. There is a pronounced relative increase of the large mononuclear cells, with a diminution of the number of the small lymphocytes and polymorphonuclears. The large mononuclears may also be increased in typhoid, measles, syphilis and possibly in influenza, but not to the same extent as in malaria. Anemia is an early symptom and of some importance in the diagnosis. The therapeutic test is last mentioned; the tertian and quartan fevers yield very quickly to quinine, and while the estivotumunal form is more resistant it is also readily amenable to treatment. Next to the examination of the blood the therapeutic test is most important; if the disorder does not abate under quinin it is not malaria. While there is not any doubt with the regularly intermittent fevers, the estivoautumnal infection may take an atypical course, without definite paroxysms, and is often confused with other diseases. The mistake, is far more often made the other way and other disorders are called malaria. Among these are mentioned typhoid fever, pulmonary tuberculosis, pyelitis, septicemia and pyemia, acute endocarditis, liver abscess and gall-stones, and the differentiating points are discussed at length. In all these the absence of the malarial parasite should prevent the too easy diagnosis of malaria. In considering the treatment Vander Hoof emphasizes three points: 1. The quinin must be absorbed and enter the blood. 2. The drug must be admin-

istered until every parasite is destroyed. 3. The patient should remain in bed until the temperature reaches normal and remains normal. The drug should be in a soluble form and the alimentary canal in a condition to absorb it. In pernicious malaria it should be got into the circulation as quickly as possible, by deep intramuscular injections and by the rectum. Rest in bed and appropriate hygienic measures greatly aid the action of the remedy in even mild cases of malaria. The post-malaria anemia usually calls for some form of arsenic: the author prefers Fowlers' solution carried up to 10 or 12 minims three times a day, if well borne.

BOOK REVIEW.

Progressive Medicine. Vol. IX, No. 1.—Whole No. 33: Contains the following articles: Surgery of the head, neck and thorax, by Dr. C. H. Frazier, Philadelphia; Infectious disease, including acute rheumatism and croupous pneumonia by Dr. R. B. Preble of Chicago; Diseases of children by Dr. F. M. Crandall of New York; Rhinology and laryngology by Dr. D. B. Kyle of Philadelphia; and Otology by Dr. B. A. Bandall of Philadelphia. A review of the progress of our art is almost necessary to the practitioner. Otherwise, the variegated mass of current literature will confuse the average man, who is so busy that he cannot take time to sift the wheat from the chaff. This particular series of such a review consists of four issues per annum, containing an aggregate of 500-770 pages, and costs \$6.00 a year. It is published by Lea Brothers & Company, Philadelphia.

Tuberculosis. as a disease of the masses and how to combat it, by S. A. Knopf, M. D., New York. Being the fourth English edition of the international prize essay. Paper. 8vo, pp. 104, with many illustrations. Published by F. P. Flori, 214 East 82d St., New York. Price 25 cents.

Every physician who has not read this essay has done both himself and his patients an injustice. In fact, every physician should see to it that his tuberculosis families read the book. Its price makes this possible. No regular publisher would undertake to publish the essay at the nominal price named by Dr. Knopf; so the doctor induced his former secretary, Mr. Flori, to undertake the philanthropic work.

It gives in popular language a very complete discussion of the cause, forms and diffusion of tuberculosis, with special reference to prophylaxis.

Psychology Applied to Medicine.—Dr. Wells has given us two or three thought-stimulating chapters in his essay on psychology to medicine. These are the first ones—wherein he discusses reason and instinct, impulse and habit, etc. Had he continued on this level, his book would have been a distinct addition to our literature.

He, however, fails to discuss, adequately at least, percept and concept, belief and knowledge, organic vs, functional health; and, the similar topics without the discussion of which no presentation of the subject could be complete.

The author very aptly quotes Saxe's "The Blind Men and the Elephant," * and for fear some of the readers may not know it, we reproduce it herewith:

THE BLIND MEN AND THE ELEPHANT.

A Hindoo Fable.

"It was six men of Hindostan,
To learning much inclined,
Who went to see an elephant
(Tho' all of them were blind,)
 That each by observation
Might satisfy his mind.

"The first approached the elephant,
And happening to fall
Against his broad and sturdy side,
At once began to bawl:
'God bless me, but the elephant
Is very like a wall.'

"The second feeling of the tusk,
Cried: 'Ho, what have we here
So very round and smooth and sharp?
To me 'tis mighty clear
This wonder of an elephant
Is very like a spear.'

"The third approached the animal,
And happening to take
The squirming trunk within his hands,
Thus boldly up and spake:
'I see,' quoth he, 'the elephant
Is very like a snake.'

*PSYCHIATRY APPLIED TO MEDICINE. Introductory studies by David W. Wells, M. D., lecturer on Mental physiology, and assistant in Ophtamlogy, Boston University Medical School. Illustrated by textual zinc etchings. 12mo, Pp. 141; cloth. Philadelphia: 1907, F. A. Davis Co. Price \$1.50.

"The fourth reached out his eager hand
 And felt above the knee.
 'What most this wondrous beast is like
 Is mighty plain,' quoth he:
 'Tis clear enough the elephant
 Is very like a tree '

"The fifth, who chanced to touch the ear,
 Said: 'E'en the blindest man
 Can tell what this resembles most;
 Deny the fact who can?
 This marvel of an elephant
 Is very like a fan.'

"The sixth no sooner had begun
 About the beast to grope,
 Than seizing on the swinging tail
 That fell within his scope,
 'I see,' quoth he, 'the elephant
 Is very like a rope.'

"And so these men of Hindostan
 Disputed loud and long
 Each in his own opinion
 Exceeding stiff and strong,
 'Tho' each was partly in the right
 And ALL were in the wrong.

MORAL.

"So oft in our theologic wars
 The disputants, I ween,
 Rail on in utter ignorance
 Of what each other mean,
 And prate about an elephant
 Which none of them has seen."

If satire could teach us anything, the recollection of this poem should make us doctors charitable—no one of us knows about disease to comprehend it, or to hoot at the disquisitions of others.

The author's real thesis is the value of pyhnotism in medic. His discussion is interesting but adds nothing to our knowledge of the subject. We believe that ever broad-mindedh physician is using suggsetion consistently and successfully. Our schools, moreover, are training their students to take into account the mind as well as the body in disease. Of course, most states, including our own, have not reached that stage of evolution where the insane who are a charge upon the state are the subjects of study by medical teachers and students. When this occurs, then we may hope to learn

something of the pathology of the mind and to have physicians who can employ mental hygiene and prophylaxis. Today we can speculate freely, but we cannot study at first hand the pathological conditions which by their contrastd envelope within our minds a concept of the normal. Just as pathological anatomy has completed our knowledge of the normal embryology, normal anatomy, and even normal physiology, so the study of the abnormal and undeveloped mind will sometime give our teachers and their students a clearer insight into psychology and the relation of mind to body. Our great hospitals for the insane should be under the care of teachers and-research workers, and should be open to students of medicin.

Dr. Wells is evidently a Homeopath, for he seems unacquainted with the work of some of the leading pharmacologists in Europe and America, but mentions as if something novel a study by eleven different groups of the effects of belladonna on the healthy person. Three "provings" may be of some value, but will only be of real assistance to him who realizes that we have already passed the night of symptomatic therapeutics and are facing the dawn of a better day—of the day of causal and specific medication.

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PRESIDENT'S ADDRESS

Delivered at the annual meeting of the Kansas Medical Society at Kansas City, May, 1907.

Mr. Chairman, and members of the State Medical Society:—Your speaker thoroughly appreciates the honor of being permitted to serve as your president for one year. The duties of the office have been very pleasant. The condition of the society is good, but can be improved. The organization of county societies is pretty thorough. However, there are some counties in the state that are not organized, and while this is true, we cannot call the work complete. There are nearly twenty-five hundred physicians in the state who ought to belong to this society; only about 50 per cent of them are now members in good standing. This is not as it should be. There seems to be a more cordial feeling existing among the members of the different schools of practice—a consummation devoutly to be wished. We are glad to come to the metropolis of the state—as there is nothing too good for the Kansas State Medical Society. Kansas sunshine, alternating with the Kansas rain, and mingling with the Kansas ozone is warming the hearts and lives of a million and a half of the crankiest and the best people God ever let the sun shine on in one sovereign state; and among the best of these are the Kansas doctors, (some of them). Perhaps there is not another class of men in the state that work as hard, for as little pay, and yet enjoys the work as well as the Kansas doctors. On a fine summer morning, as the Kansas doctor is making an early call, as his automobile is whirling along the highway, the dew is sparkling on every

flower, and shrub, and blade of grass, the voices of a thousand birds and insects greet the ear, and the balmy air fans the cheek, the tall sunflower nods to the sun, and the waving grain sways in the breeze. Then it is that all nature conspires to make the Kansas doctor glad he is alive, glad he lives in Kansas, glad he belongs to our noble profession. An old friend of mine recently said, "I have yet to find in any profession a larger per cent. of honest, industrious, intelligent, unselfish, patriotic and self-sacrificing men than are found in the medical profession. Out on the virgin prairie where there are no marks of civilization, you will find no sunflowers. But plow a furrow, dig a ditch, make a road, go away, and return in after years, and you will find that wherever the sod was broken there are sunflowers in profusion. Cut them down, dig them up, burn them, anything you please, the following year they will be more numerous than ever. They came to stay—typical, as we fully believe of the Kansas doctor. He did not come with the wild adventurers who first saw the land. He came with civilization, to build a home, to help build schools and churches, to help make a great state. And here he has remained, able and willing to assume the duties and responsibilities of useful citizenship. And let the Kansas doctor wander away in quest of business or pleasure, soon he will be dreaming of the Kansas sunshine, and the Kansas sunflower, and ere long he will come back—verifying the old adage—"Once a Kansan, always a Kansan." The history of the progress of medicine furnishes a part, no small part, of the valuable literature of the world. Not every year may we record such marked advances as were made when Dr. Harvey discovered the wonders of the circulation of the blood; or when Dr. Jenner gave to the world the benefits of his studies on the subject of vaccination; or when the germ theory was established, or when general anaesthesia was found to be possible, or when the true value of antiseptic surgery was first demonstrated, or when the surgeon first proved to us that the cavities of the body may safely be entered with the knife and the so called vital organs be altered or removed with safety; or when we found the local anaesthetics, or the antitoxines; or when the world first came to know that the mosquito was something more than a nuisance. However, we are proud to belong to a profession that takes no backward steps, and the past year is no exception to the rule; it has shown steady advance along scientific lines, and has added not a little to the honor of the profession. One of the most gratifying things to report for the year is the tendency toward specialism in internal medicine. In fact, it has come to the

point when it does not seem absurd to say of this, or that, internist: "He is a specialist." For some years past our profession has drifted into all manner of specialties, and has sadly neglected internal medicine. This gave opportunity to the fadist, and he was not slow to take advantage of the opportunities that presented themselves. This to the chagrin of the regular profession, and in too many cases, a sad curtailing of the legitimate income. It is hardly to be wondered at, when perhaps many of our ablest men were giving but little thought to therapeutics and saying, "Well, I don't give as much medicine as I used to, I think we have all been in the habit of giving too much medicine, we must pay more attention to hygiene, to nursing, to comfortable and pleasant surroundings; to diet, to cleanliness, to suggestion, to change of climate," and so forth. What more natural than that our patients should in some way get to understand our sentiments in the matter, and they too, become dissatisfied and want to try something else. To illustrate: Some years ago, while doing general practice in the central part of the state, there was on one side of the village a community made up very largely of people of one nationality. I, with others, did considerable practice among them. Gradually I began to hear that friends of some of my patients, living in Nebraska, were writing them of a wonderful doctor that had come to their neighborhood; of all the great things he could do, etc. Soon it became evident that there was a determined effort being made to induce this great man to come to Kansas and locate in this neighborhood. The excitement became great when it was learned that he could come. And so he came and located with a farmer some miles from town. He was a small, dark, weazened faced, long haired, greasy looking individual. He had a large dirty black book. When a patient came to consult him he would look solemn and in a fierce voice he would say, "I don't want to hear a thing about your case, I can tell all about you without knowing anything of your history." He would gaze into the patient's face with an air of mystery, and ask: "When were you born?" The date, tremblingly given, the great man would turn slowly to the old black book, and after an apparent careful reading he would exclaim, "Ah, I thought so. You were born between the planets so and so. It is indeed fortunate for you that I came when I did, soon it would have been too late. Here," he would say, "take this and you will recover from this terrible malady;" and he would hand out a vial about the size of my little finger filled with a liquid almost colorless, at the same time stating that he had a man in Africa gathering the raw herbs from which this

medicine was made. That it was very expensive. That no one else in all the world knew about it but he and his man, and that it would cost them just \$2 strictly cash. And this would be paid with perfect willingness. It is somewhat humiliating to relate that my practice fell off 90 per cent. in that community, and I candidly believe he took more money out of that neighborhood in the six months he remained there than I did in six years. Of course they found him out, and he had to move on, and I came into my own again. It seems to me that if the regular profession had been fully alive to the situation, such a sentiment could not have prevailed in any community. The present trend is towards a better sentiment, and it is becoming more and more difficult to deceive the people, and I believe the internist will be more and more appreciated in the future. He is becoming more and more proficient, and scientific, and pains-taking in his work; and more worthy of the confidence of the public. And, mark you the fadist is going to have more trouble about discrediting legitimate practice as the years go by. The time has come when the General Practitioner in order to keep up with the procession, must be thoroughly posted in laboratory methods of diagnosis, and this in itself promises to become a specialty before long. The tendency now is to have fewer patients, and give them better service, and charge accordingly." The number of patients that can be seen and properly cared for in a day, by one physician, is not very great. The sins of omission are probably greater in the practice of medicine than are the sins of commission—made through negligence rather than through ignorance." Myer says, "That physician who overlooks a beginning nephritis, an incipient tuberculosis, or an early valvular lesion, through an incomplete examination, commits by far a greater error than he who prescribes an over dose of a drug. The one is caused through negligence, while the other may be caused by one of those tricks of the mind of which we are occasionally victims." "In order to be conscientious in our work, it is necessary that we see a limited number of patients, and give each one a most searching examination, no matter how slight the ailment, and then measure our success by the quality and not the quantity of work done. I fear that the general practitioner who boasts of seeing fifty or sixty patients a day, is a menace to his community. Many of his mistakes may never be revealed, but they are there just the same. Preventive medicine yields its best results when there is a desire to give to every patient an opportunity to use an ounce of prevention, instead of a pound of cure. It has been claimed that preventive medicine may be employed only in diseases

of bacteric origin. We believe that preventive medicine may be employed by the internist through the recognition of the incipient stages of all diseases."

No doubt much of the progress that has been made in internal medicine during the year, and during the past few years, is the result of the awakening of the physician to his duties to his patients as well as to the science of medicine. We hear little these days of trouble and rivalry between the general practitioner and the specialist. We are hearing more about the border line of medicine and surgery. Certain diseases of the stomach, the gall bladder, the kidneys, and so forth, that the family physician used to treat with palliative medicines, he is now glad to turn over to the surgeon. This has come about by a closer association of these two classes of practitioners. Palliative treatment has so generally failed in so many cases, and surgery has succeeded, that few care to dispute the facts. Asepsis enables the surgeon to do successfully much that he dared not undertake in previous years. Janeway warns against the danger of unfulfilled predictions, and too great optimism. He says there is danger of bringing surgery into disrepute, through operating in hopeless cases, and charging a large fee for the same. In these border line cases, nothing else is so important as an accurate diagnosis. All available means should be employed in order to form a correct diagnosis; and this must not be left to the surgeon alone; for in many of these cases it is the Internist who must decide when surgical procedure is desirable. Take for instance, the danger of hemorrhage in cases of protracted jaundice, and the importance of an early decision in regard to the probable need of surgical intervention. Again, operations upon the kidneys for decapsulation have shown that the presence of albumen and casts, is not contra indicated in anaesthetics and surgical procedure. The general practitioner frequently decides as to whether or not, the degree of anaemia present is such that he must advise against surgical interference, until an attempt has been made to bring about a better blood state. It is important, both to the patient and to the science of medicine, that the Internist and the surgeon shall work together in harmony.

The Mayos report 34 gastric resections in the last thirty months for cancer; with 14.5 per cent. fatalities; and they claim that without surgical procedure these cases show 100 per cent. fatality. Goldschuetcker, reviews in detail the results of surgery in perforation, in ulcer of the stomach, and states that about 50 per cent. of these cases are cured through operation.

Boas thinks that 80 per cent. of all rectal carcinomata which are

within view and may even be palpated, come to the surgeon too late for operation. This being the case, carcinoma of other portions of the intestines, offer even poorer chances. Among the border line diseases between surgery and medicine, gall stones may be mentioned. And while it is a fact that it has been the custom to operate in all cases just as soon as the diagnosis could be made, during the last year, some of the best men have said, that a rational therapy should first be carried out, and then if not satisfactory, surgery should be resorted to. Ulcer of the stomach has received during the year its usual amount of consideration. The consensus of opinion seems to be, that the most important thing to do is to keep the patient in bed, keep ice over the stomach, then enforce much fasting, and very careful feeding. During the year the work on Opsonins and vaccines has attracted much attention; and promises to be of great value in the future. Wright, of London, has probably done more than any other man in making the opsonic theory popular. The term is based upon the word opsono, meaning, I prepare for food. Wright, aided by others, has perfected a method of determining the phagocytic property of serum, and found that sera of all apparently healthy individuals, contain practically equal amounts of these bacteria affectiong substances, which he calls opsonins. This subject is being carefully studied in its relation to tropical diseases, and is probably resulting in much good.

Speaking of tropical diseases, it may not be out of place to refer to the fact that our interests in this matter have materially increased since the acquisition of our island possessions, and especially since our occupation of the canal zone. There is no question but that one of the greatest problems to be solved, there, is the prevention of diseases peculiar to that country among the workmen employed. President Roosevelt has recognized that, without the proper state of sanitation, the canal cannot possibly be completed, and it is gratifying to note that Dr. Gorgas has already done admirable work, and yellow fever has been practically eliminated from the zone. He calls attention to the great mortality on the Isthmus of Panama during the French occupation, and compares these figures with the ones that have been obtained during the American occupation of the canal zone. The result of his work has been the practical elimination of yellow fever from the zone. In June last, they had 67 cases, in July 40 cases, in August 27 cases, in September seven cases, in October three cases, and none in November and December. However, Dr. Gorgas says it will be several months yet before we can determine whether or not, yellow fever has been

eliminated from the Isthmus. After a plainly perceptible lull, the X-Ray as a diagnostic aid in internal medicine, is becoming more and more popular. That it is a most valuable aid, can no longer be questioned. Stones in the kidneys, ureters, and bladder, are shown by the radiograph with marked precision. Radiologic diagnosis in connection with gastro-intestinal diseases, is especially noteworthy. In early involvement of the lungs, too, much may be learned through the application of the rays. The X Ray machine is not used now just as an advertising medium. Time was when that was the principal use made of this really valuable part of the reliable physician's armamentarium.

The leucocyte count has won for itself a well recognized place in surgical diagnosis. The differential leucocyte count, is not yet as generally used as its value warrants. Gibson believes that the differential count, and its relation to the total leucocytosis is at present the most valuable diagnostic, and prognostic aid in acute surgical diseases, that is furnished by any of the methods of blood examination.

And now they tell us that it is possible to demonstrate the presence of tyhoid bacilli in the blood long before the widal test becomes positive. Conradi describes a simple method which makes it suitable for the general practitioner. His culture medium consists of Ox Gall, to which 10 per cent of Peptone and 10 per cent of Glycerine have been added, the mixture being contained in test tubes and sterilized. Eight to thirty drops of blood are withdrawn from the patient's ear directly into the tube, under the usual aseptic precautions. The tubes are placed in the incubator over night, whereupon the bacilli, if present in the blood, will have grown profusely. The contents of the tube may be found over Agar plates, and the resulting colonies identified by the usual methods. Formerly the difficulty, and complexity of the procedure has stood in the way of its general use. The rather astounding statement is made by one of the best of our American surgeons within the year, that in his opinion, modern gastric surgery is less than five years old. He thinks the most striking advances which the year 1906 records can be ascribed to this field.

Nervous people may not appreciate the statement recently made by HolznKecht, viz: that after careful and thorough investigation he finds that a normal stomach is very uncommon, and that most of us have a displacement downward. However, we should take courage as we think of the posterior no-loop gastroenterostomy of the Mayos. The large per cent of recoveries reported by the Mayos,

and many others recently when they have resorted to surgery in ulcer, and perforation of the stomach and addonem, is certainly most gratifying. W. J. Mayo states that 30 per cent of all cancers occur in the stomach. He and his brother have operated on 313 of these cases. One hundred of them in 1906, with a mortality of 14 per cent. Robson reports about the same mortality, which is probably much lower than the average. All agree the great trouble is to have an early diagnosis. Dr. Carl Fisch, an excellent authority on pathology and bacteriology, while believing that the work done in this field the past year has in many respects been very gratifying, yet expresses regret that more has not been accomplished. He says the work done in this direction is enormous, but, looked at from the point of view as to whether or not, a definite basis has been established, seems rather unsatisfactory. He thinks these matters will probably undergo a revolutionary alteration. However, he thinks the work of the year has broadened the field very much, and therefore, made it more promising. But ever since Schleiden, many, many years ago, established the cell as a unit, thus giving us one of the most important achievements of the last century, we continue to believe this field offers as great inducements to the minds of the studious of our profession, as can be found in any other department of our great work. Why not? Since on it is based all of our deeper knowledge of the life of protoplasm—of life itself. Our teachings on the functions of life are derived from the study of cells. Our principal physiologic, biologic, and pathologic acquirements are founded on it. The cell, today reigns supreme as the primary factor in life and death. Its study is within the limits of our mechanical appliances. This study has furnished the profession knowledge so extensive as not to be excelled. Cells were, and are today, and will continue to be the basis of every study of structure, function, and life. The time allowed will not permit me to speak of advancement made in many other of the numerous and important fields of our labor. Suffice it to say, that it is no exaggeration to say that there has been encouraging progress along all lines.

I know you will pardon me for referring to a matter somewhat personal. You will call to mind the fact that a certain article in a recent number of Kansas Medical Journal, which if true, makes it no exaggeration for me to lay claim to being the manager of the largest boarding house in the state of Kansas, and a farmer, more or less, up to date. We have about thirteen hundred boarders now, and it requires about two hundred men and women to run both farm and boarding house. It also requires five physicians. If you will

examine our last biennial report, you will find that the gratis operations in plastic surgery and gynaecology alone, done by our medical staff, would cost, if paid for at current prices, more than twenty-five thousand dollars. It had not occurred to us that we were so unscientific. The article above mentioned states that no scientific work is being done in any state hospitals for the insane, except in Illinois, Ohio and Massachusetts. If this is true, it is somewhat astonishing that from our Kansas state boarding house the percent of restorations is as large, in fact larger, than is shown by the reports of those institutions, scientifically conducted in the above named states. The scientific methods hinted at by author of the article, are old in the Kansas state hospitals. And there is no doubt that this could be truthfully said of the state hospitals of a large majority of the states of the Union. The enactment of the Pure Food and Drug Law by the federal government, is a long stride in the direction of progress. It is very gratifying to our profession, that a law, corresponding very closely to the national law, was passed by our last legislature. The fact that this law is in harmony with the National law will make its enforcement more certain. There can be no doubt that properly enforced, this law will be of great benefit to the general public. Too much credit cannot be given to our worthy secretary and the other members of the profession, for their work along this line during the last session of the Kansas legislature. The indications are that the effective work done in recent years by our profession in the nation, will finally result in a cabinet member to look after public health.

Some one has said that *Ad Astra Per Aspera* means the attaining by Kansas through her difficulties, of a place in the National Constellation. But those who have observed know, that this is no mere statement, but a fulfilled prophecy. She is there NOW. And the Kansas physicians are climbing through some difficulties, to a higher plane of intellectual and scientific attainment.

L. L. UHLS, Osawatomie, Kansas.

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THE VALUE OF BLOOD EXAMINATION IN CHILDREN.

By MERVIN T. SUDLER, Professor in the School of Medicine of the University of Kansas.

During the past year several articles have appeared upon this subject by men who are either specialists in clinical examinations or who have had wide experience in the results of blood examination and its relation to practical clinical problems. These papers agree in all of the essential facts, showing that this subject is one of value and well worthy of study by those who wish to make careful, accurate diagnosis.

The results given in this paper are based on examinations made in the last eighteen months on children varying from two to sixteen years of age. Those representing normal conditions were all under ten and over two years of age. In most cases where disease existed, a leucocyte count and haemoglobin estimation was all that was made, unfortunately. However, in a few of the later ones complete differential counts were made, and while this number is not sufficiently large to give statistics from which to draw new conclusions, it is large enough to compare with the results of other observers who have had a sufficient number to be used for statistical purposes.

Now that the development of our knowledge of opsonines and vaccines is developing so rapidly, and the methods in use are so related, it seems that these methods will become much more interesting and valuable. The examination of the normal children was made here in Lawrence and most of them represented the acme of healthy childhood, rosy cheeked and well nourished, some of them to a remarkable extent. Most of those of diseased children were made by the writer while resident surgeon in St. Mary's Hospital for Children in New York, but a few have been added from private practice in Lawrence.

The Von Fleischl instrument was used in making the Haemoglobin estimation, for after a careful preparatory comparison with the Talquist scale it was evident that with the arthur the amount of error was much less when the former was used. The usual methods of counting the red and white corpuscles with Thomas Zeiss Blood

1 The value of the Differential Leucocyte Count in a Diagnosis.—By Frederick E. Sondern, M. D. The American Journal of the Medical Sciences, Dec. 1906.

2 Value of the Differential Leucocyte count in acute surgical diseases, C. L. Gibson, Annals of Surgery, April, 1906,

Counting Apparatus were used. In making the differential counts carefully cleansed slides were used. Smears were made on them and they were then stained with Wright's triple stain and the percentage estimated from a total count of at least two hundred in the pathological cases and from three to four hundred in the normal cases. In some cases it was computed separately from different slides of the blood of the same child.

TABLE SHOWING THE RESULTS OF THE BLOOD EXAMINATION OF TEN NORMAL CHILDREN UNDER TEN YEARS OF AGE.

No.	Age	Sex	Haemoglobin	Reds	Leucocytes	Polymorphonuclear	Transit Corials	Large Mononuclear	Lymphocytes	Eosinophiles
1	7	boy	85	4,768,000	8,660	74.	per ct	8 per ct	15 per ct	23.
2	2½	girl	80	5,280,000	10,400	67.3	5	3.	29.	12
3	9	boy	73	4,528,000	8,000	50.3	0	5.5	43.	3
4	3	girl	74	5,010,000	8,400	52.	7	5.6	35.	7
5	9	boy	73	4,620,000	9,600	60.5	0	2.6	31.	1.1
6	5	girl	80	4,690,240	5,600	60.4	1.1	5.1	35.5	1.1
7	8	boy	70	4,620,000	5,750	61.4	1.6	4	32.	5.8
8	9	boy	72	5,260,000	10,100	56.1	4	3.3	38.	2.6
9	6½	girl	95	5,088,000	10,700	61.2	7	4.5	32.	7
10	9	boy	85	5,200,000	9,400	52.4	1.1	6.1	39.	14
Average.....			78.7	4,606,424	8,655	57.56	7	4.13	34.6	12

TABLE OF THE RESULTS OF THE BLOOD EXAMINATION OF CHILDREN SUFFERING FROM LOBAR PNEUMONIA.

No.	Age	Sex	Day of Disease	Haemoglobin	Leucocytes	P.M.N.	Transit	Lrg. Mono	Lympho	Eosin	Result
1	5	girl	6		16,000						
2	12	boy	8		10,999						
3	5½	girl			21,000	87	4	3½	55.		Death 9th day
4	3	boy	52	per ct	30,100	81	2	3½	13	.5	Recovery
5	7	boy	45	"	21,800	74	3	2	18		Recovery
			75	"	27,000	79	1	2	16	2.	Recovery

TABLE SHOWING THE RESULTS OF BLOOD EXAMINATION FOR VARIOUS DISEASES.

Disease	Age	Sex	Haem	L uc.	P.M.N.	T	L. M.	M.	E.	Result
Empyema—Left. Pure culture of streptococcus	27 mos.	girl		37,000	69	3	5	23	5	Recovery
Typhoid	4 yrs.	girl	65 p c	7,000	67	1.7	4	27	.3	Recovery
Measles, see No 9 normal children	6½ yrs.	girl		3,400	39.7	0	10 Legs small	47	1.6	Rapid Rec
Mal-nutritious, poor food, etc Tubercular Peritonitis [Perforation]	5 yrs.	boy	65 p c	11,200	30	4	66		.51	Recovery
Tubercular Cervical adenitis and miliary tuberculosis	8 yrs.	boy		18 000	73	2	5	20	2.	Died
	9 yrs.	girl	35 p c	8,600	66	2	10	22	.5	Patient removed from hospital in almost moribund condition by relatives.
Tubercular cervical Adenitis	1 year	boy	45 p c	13,000	80	3.5	3	13	.5	Recovery from operation.
Multiple tubercular bone lesion with mild infection	4 years	girl	45 p c	13,500	73	5	2 Legs small	21	1.	Slow Improvement.
Tubercular knee (right)	5 years	boy	55 p c	15,000	29	4	65		2	Improved
Perinephric abscess, Staphylococcus aureus	16 yrs.	boy		36,000						Recovery following operation.

With only these few examinations from which to draw conclusions general impressions rather than exact statements of facts are all that are justified.

These are as follows:

The Haemoglobin of normal children under ten years of age is about 75, probably a little lower in cities and higher in individual cases and in the country such as we practically have in Lawrence.

The red cells are nearly 5,000,000 to the cubic millimeter.

The leucocytes about 8,500. Both are a little higher than adults would average unless unusually well nourished.

The normal percentage of polymorpho-nuclear leucocytes is about 58 to 63, small Mono-nuclear leucocytes 30 to 35 large mono-nuclear leucocytes about 3 to 6 per cent; Eosinophiles about 1.5 per cent; and transitionals about 1 per cent.

These proportions are quite easily affected. In fact it seems that the whole equilibrium of the various constituents of the blood are much more easily affected and altered than in adults. Just as the temperature reactions of children is more delicate and variable than that of adults, so that relatively slight disturbances in a child may bring about changes in the blood which would mean much more in adults. In perfectly normal children there is a greater variation of leukocytes than in adults. In the differential count the percentage of lymphocytes is higher and the younger the child the higher it is. This increase is very well shown in the chart of blood counts of normal children.

The increase in leukocytosis in pneumonia is very great and in the differential count the high percentage of polymorpho-nuclear forms is greatly increased. The one fatal case noted had but a small leukocytosis and this decreased as the fatal termination was approached.

The examination of the blood during measles was made on the same child as number nine in the normal cases. The absence of leukocytosis is very emphatic. Her extremely rapid and complete recovery from the effects of her illness emphasizes, however, the importance of having the "blood in good condition." Number two was a sister, and her recovery from measles was even more prompt. Both were extremely well nourished children. The great lowering of the Haemaglobin in tubercular cervical adenitis and other tubercular lesions, is the most striking feature of the blood picture in all the cases examined. In some cases an increase is shown in the lymphocytes rather than in the polymorpho-nuclear form, so that the ordinary percentage is about reversed but this is not constantly true, and was not found in any case having mixed infection. Sondern and Gibson both emphasize the importance of the abnormally high percentage of polymorpho-nuclear forms as well as the relative increases in the total number per cubic millimeter in surgical inflammatory conditions. This, also, in children shows some variability. From these results it is seen that while a blood examination is of the utmost importance and that in many cases a diagnosis may be made on that alone, still, in children it is more variable than in adults and should be taken only in connection with all of the other signs and symptoms available. Used in this way it will often bring us to a correct diagnosis. When taken by itself its weight should be that of a suggestive and important symptom with its importance varying in the disease suspected in the individual, its value being greatest in diseases of an inflammatory character.

THE JOURNAL OF THE
NYSTAGMUS.

J. S. WEVER, M. D., Bryant Bldg., Kansas City, Mo., Attending Oculist and Aurist German Hospital, Kansas City, Mo., Consulting Oculist and Aurist, Leavenworth Hospital and Cushing Hospital, Leavenworth, Kan.

Relative to the subject illustrated by the four cases herewith presented by me, the best descriptive information obtainable was found in Posey and Spiller's "Eye and the Nervous System," (1906), from which the following is largely drawn:

VARIETIES OF EYE TREMOR.

A. **SEARCHING MOVEMENTS.**—Found in blind eyes and eyes with loss of central fixation power. Wide, comparatively slow movements from the primary position and return.

B. **PSEUDONYSTAGMUS.**—An extreme effort to keep up an original, excursive movement resulting in a series of spasmodic jerks, usually bilateral and in the direction of the intended movement. Occurs constantly in hereditary ataxia and is usually marked. Frequent in multiple sclerosis and also in healthy people and is therefore not a diagnostic sign.

C. **NYSTAGMUS.**—Smooth, regular, constant, short, quick oscillations about a central point occurring in any position of the eyes.

D. **MIXED FORMS.**—Occur usually when loss of central fixation is coupled with restriction of movement.

NYSTAGMUS.

NUMBER, EXTENT, SYMMETRY AND VARIATION OF MOVEMENT.—From 60 to 240 per minute, either horizontal, vertical, rotary or mixed and not usually far in any one direction. Nearly always bilateral, parallel and equal. Fifty-two cases of unilateral type reported and nearly all vertical. Variations in movement may occur as the result of nervous excitement, reduced illumination, use of alcohol, eyes being turned in some particular direction, covering one eye, nearness of object looked at, adducting prisms, etc. The movements are reduced by closing the eyes and cease during sleep.

ETIOLOGY.

A. **OPTICAL OR INFANTILE.**—Corneal opacities, microphthalm-

Read at the Forty-first Annual meeting of the Kansas State Medical Society, May, 1907, Kansas City, Kan.

mos, strabismus, abnormalities of the retina and choroid, albinism and refraction errors (latter may develop later in life).

B. OCCUPATIONAL.—Miners, compositors, paper-makers, etc. as the result of prolonged fixation particularly in an upward direction.

C. AURAL.—Disease, injury or pressure on the labyrinth.

D. NERVOUS DISEASES.—Multiple sclerosis (12 per cent Uthoff) and Syringomyelia; otherwise rare in nervous diseases but does occur in epilepsy, multiple neuritis, lesions of the fourth ventricle, restiform body and cerebellum and in hysteria.

E. TRANSIENT.—Often with ether, sometimes from alcohol, cocaine, sulfonal, arsenic, lead, quinine, ergot, benzene, eserine and sewer gas. Also from irritation (inflammation or foreign body in the eye and muscle operations) or in spasmodic nutans.

SITE OF THE LESION. In nervous diseases usually of central origin, as mentioned under etiology. In other cases seems to be of reflex origin.

THEORY OF NYSTAGMUS. There is no perfectly satisfactory explanation yet given. It is probably a perversion of the centers for parallel and parallel-rotary movement and not lesions of the muscles or their nerves. Brain impulses are supposed to alternate instead of coming simultaneously. It is really perverted fixation. A child is not born with the power of fixing an object with the eye, and if the visual power is low the child does not learn to fix an object with the eye and keep it still. Individuals born with eyes absolutely blind do not have nystagmus. The fact that some individuals with good vision do have nystagmus and the fact that low vision is more likely to cause strabismus than nystagmus makes it necessary to add some other etiological factor to the low vision.

SYMPTOMS. Objective symptoms, movement particularly of the better eye in a supposedly unilateral case may be demonstrated with the ophthalmoscope.

SUBJECTIVE. 1. Apparent movement of objects (not present in congenital cases). 2. Reading in vertical lines. 3. Vertigo. 4. Head nodding. 5. Poor vision. 6. Photophobia.

COURSE. Infantile type generally permanent. In other types if the cause is removed the nystagmus stops.

TREATMENT. Glasses may or may not improve the vision but seldom cure the nystagmus. Rarely, cases have been benefitted with exercises with stereoscope, rotating prisms, perforated diaphragms, also by muscle operations. Change of occupation and removal of drugs will cure cases where they are the causative factors.

I believe any general nervous stimulant such as coffee, tea, alcohol and tobacco should be interdicted.

Case 1. Oct. 20, 1901. R. T. age 20, grocery clerk, Vision R. E. 1-60 improved to 2-60 with -5.00 sph.—Vision L. E. 6-30 improved to 6-15 with -1.00 sph. with -3.00 cyl. axis 20. Eye movements lateral and rotary, worse in right eye, persist even with eyes shut. This boy's brother, seven years older, with higher refractive error in each eye did not have nystagmus and his vision was improved by glasses from R. E. 2-50 and L. E. 4-50 to 6-10 in each eye. This case received a blow from the point of an umbrella falling from the top of a door when he was an infant and striking on the cerebellar region of the skull, but leaving no mark.

Case 2, April 23, 1903. E. T. age 6, vision in each eye improved from 6-60 to 6-20 (?) with R. E. plus 1.50 cyl. axis 110 and L. E. plus 1.75 cyl. axis 80. Re-examined Aug. 16, 1904, with same result. A slight change was made in lenses July 21, 1906. Mixed nystagmus of both eyes. It is four years since I first saw this case. He has developed fairly well mentally and physically, but the vision and the nystagmus are about the same as when I first saw him.

Case 3 E. M., tinner, first saw this case Feb. 25, 1903, four years ago, then 22 years old, with an attack of iritis in the left eye, which with an ulcer lasted about five months. Saw him once in 1904 and again with an ulcer of the cornea of the left eye in February and March, 1906, and again within the last two months with another ulcer of the left eye. The old scars under the chin (keloid-like) are probably from old tubercular glands. The vision of the left eye is still good enough for him to read fine print and do his work in spite of some defect left by the ulcers. The right eye had a stick thrust into it when he was four years old, and the iris is now almost completely imbedded in the scar extending the width of the cornea. He can see fingers moving at five or six inches with this eye. The right eye deviates out about thirty degrees. The right eye shows pseudonystagmus when carried to extreme points of rotation.

Case 4. Feb. 16, 1907. W. M., colored, age 15, coachman.—In the right eye there is a dense corneal scar which limits vision to perception and projection of light. There is a small scar in the left cornea in the upper nasal quadrant. These scars are probably from ophthalmia neonatorum. Vision of the L. E. is 6-60 improved to 6-30 with a -9.00 sph. There is some astigmatism present but it could not be estimated on account of the nystagmus.

REMARKS. Of these four cases, 3 and 4 are similar in that an infantile lesion prevented the development of the fixation power but 3's left eye had practically no refractive error while 4's left eye had very high myopia and a corneal scar with nystagmus. Cases 1 and 2 had moderate refractive errors without eye lesions. None of these cases had evidences of aural or nervous diseases and the ophthalmoscopic findings where they could be made were negative. Case 4 has head movements occasionally. Case 2 has photophobia occasionally. Outside of glasses and suggestions in regard to general

health no treatment has been recommended. In the light or rather the darkness of our present knowledge of the subject I do not feel justified in attempting any operative procedure. And when we consider how little exercises accomplish in the less complicated phorias and tropias I have little faith in any result from them.

REFERENCES

- System of Dis. of the Eye Norris and Oliver. 1899.
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OFFICIAL REPORT.

The forty-first annual meeting of the Kansas Medical Society was held at Union Club Hall, Kansas City, Kansas, beginning Tuesday, May 7, 1907, at 8 o'clock. The meeting was called to order by the president, Dr. L. L. Uhls, and the address of welcome was delivered by George M. Gray, Kansas City, to which Dr. F. M. Daily, Beloit, responded.

ADDRESS OF WELCOME: Dr. George M. Gray, Kansas City, Kansas.

Gentlemen of the Kansas Medical Society, I do not know why I was selected to deliver the address of welcome unless it was that I have lately filled out a piece of a term as mayor of the city. On behalf of Kansas City, Kansas, I bid you a cordial welcome to our city. Though I am only an ex-mayor, I have some, (or am supposed to have some) "pull" with the present administration; which, I suppose, is the reason for my being selected for this position. Kansas City, Kansas, the metropolis of the state of Kansas, feels proud in entertaining so distinguished a body of medical men as this, the Kansas Medical Society. Kansas, which is, I believe about the geographical center of the United States, is fast coming to the front with its institutions of learning. The medical department of the state university has the clinical department at Rosedale, a suburb of this city, and one we expect to take in before long; and, along with it, the medical department of the state. We have here two large charity hospitals, St. Margaret's with some 300 beds; and Bethany, with a somewhat smaller number, both of which institu-

tons are used by the medical department of the university of Kansas in their clinical teachings. We also have here an institution for the education of the blind, and the state may justly feel proud of what is being accomplished in this institution. In this city, we have seventy miles of paved streets; and are just now laying out a system of parks and boulevards which, when completed will make Kansas City, Kansas, an even better place to live in.

Truly, for a city of 80,000 we are poorly equipped with large hotels which are a necessity for a gathering like this, but it is with pleasure, I can assure you, that just now we are completing one of the finest fireproof hotels in the west; and we had expected it to be in operation for this occasion, but unfortunately, it has been delayed about a month.

I hope that you will have a good time; and I trust that your visit to this city will be both profitable and pleasant.

Again, I bid you a hearty welcome to Kansas City, Kansas.

RESPONSE TO THE ADDRESS OF WELCOME:

Dr. F. M. Daily, Beloit.

Physicians of Kansas City, Kansas: In behalf of the members of the Kansas Medical Society, we desire to thank Dr. Gray for his address of welcome; and to thank the physicians of Kansas City, Kansas, for their efforts to make the visit of our society both pleasant and profitable. At the last meeting of the Kansas Medical Society, held in Topeka one year ago, your distinguished citizen and physician, Dr. E. J. Lutz, extended an invitation to hold this meeting in Kansas City, Kansas; and, if I mistake not, the invitation was unanimously accepted. I mention this in order to show you the esteem and confidence in which the physicians of Kansas City, Kansas, are held by the Kansas Medical Society.

We desire to congratulate your city on her good fortune on having located so near by the medical department of our great state university; and we predict that not far in the future, Kansas City will be recognized as the medical, as well as the commercial, metropolis of the west. The members of the Kansas Medical Society are proud of Kansas, of her citizens, of her great educational institutions wherever they may be located; and last, but not least, we are proud of Kansas City, Kansas, and the good judgment displayed by her citizens last year in placing the administration of our city affairs in the hands of one of the honored members of our society.

Physicians of Kansas City, Kansas, we thank you!

Report 2: On motion of Dr. Goddard the reading of the Minutes of last meeting was dispensed with.

Reports:

Secretary—

Treasurer—

Editor—

Report of auditing committee—

Report 3—An informal talk was made by Dr. Bolton of Iola, on the evils of lodge practice, which opened quite a lengthy discussion, at the close of which Dr. Bolton made a motion that a committee of two be appointed to go before the state meeting of the Fraternal Order of Eagles, at Iola, to be held the 13th, 14th and 15th of June, having their expenses paid by the society, to present before the body of Eagles the evils of lodge and eerie practice. The motion being carried, Drs. Goddard and Jarrett were appointed to represent the society.

Union Club Hall, Kansas City, May 8, 1907.

Report 6—

After the opening of the meeting by the Chairman at 9 o'clock, neither of the vice-presidents being present, Dr. Goddard officiated as chairman, while Dr. Uhls presented his address.

Meeting of House of Delegates at Kansas City, May 10, 1907.

Called to order by Dr. L. L. Uhls, President. Forty-one delegates being present. A resolution was adopted, giving each county society a representative, from the members present—provided the regular delegate was not in attendance. This being the date for election of officers. The following officers were elected for the ensuing year:

J. E. Sawtell, Kansas City, President; Thos. Kirkpatrick, of Garnett, M. F. Jarrett, Ft. Scott, and Geo. M. Gray, Kansas City, Vice-presidents. L. H. Munn, Topeka, Treasurer; S. G. Stewart, Topeka, Librarian; O. P. Davis, Topeka, Councilor, fifth district, term three years; H. B. Coffey, Pittsburg, Councilor second district, term three years; Preston Sterritt, Kansas City, Councilor seventh district, term two years. The last named councillor was elected to fill the vacancy caused by the election of J. E. Sawtell to the presidency of the society. L. L. Uhls of Osawatomie, and H. L. Alkire of Topeka, were elected delegates to the American Medical Association for the term of two years. C. E. Bowers of Wichita, was elected delegate last year and holds one year yet.

This is the first time in the history of the society that it was entitled to three delegates to the A. M. A.

Motion made and carried that each delegate select his own alternate, if he found it would be impossible for him to attend the A. M. A.

Dr. E. J. Lutz made an interesting report of his work as a member of the committee on legislation of A. M. A., while in Washington, with the other members of the committee during the session of the last congress. He said it was very important to closely watch all legislation effecting the medical profession and enforcement of the Pure Food Laws.

The president reappointed Dr. Lutz as member of the committee on legislation of the A. M. A. from Kansas.

Motion was made and carried "That it was the sense of this meeting that no temporary permits to practice medicine be granted by the board of medical examiners and registration."

Resolution No. 1—The following was introduced by J. W. Bolton and unanimously adopted: "That we condemn all manner of contract practice as being unworthy of the dignity of the medical profession."

Resolution No. 2—Whereas the fee for the examination in fraternal insurance organizations is insufficient, and the fee in old line insurance companies has been reduced, Therefore, be it Resolved that we deem it advisable not only for the benefit of the these societies, but the profession and that the fee be raised to a reasonable compensation, and where the old line companies have cut the fee to three dollars, it be raised to five.

Resolutions—Whereas, the accurate registration of vital statistics is an indispensable requisite of an efficient modern public health service, and

Whereas, the congress of the United States, by joint resolution, has called upon the authorities of the various states to co-operate in establishing such registration; therefore be it

Resolved, that we, the members of the Kansas State Medical Society, assembled in annual meeting at Kansas City, Kansas, do hereby most earnestly recommend to the next legislature of Kansas that a law be enacted which shall provide for the thorough and complete registration of vital statistics throughout the entire state, and especially that all deaths, with the causes of deaths, be recorded, by means of standard certificates as recommended by the U. S. Census Bureau and American Public Health Association, and that burial or removal permits be issued prior to any disposition of the body.

Resolved, that a special committee of three members of this so-

ciety be appointed to co-operate with the state board of health of Kansas and with the U.S. Census Bureau, in drafting and supporting a satisfactory bill for this purpose; and

Resolved, that the achievement of the registration of all deaths, with their causes, immediately after their occurrence, and the prompt return of certificates of death from local registrars directly to the central bureau of vital statistics which shall constitute a part of the organization of the State Board of Health, thereby giving the sanitary authorities of the state timely information of the exact prevalence and distribution of disease, is the most important of all sanitary measures and should be unremittingly urged until successfully carried out in this state.

The last two resolutions were also unanimously adopted and according to the provisions of Resolution No. 3, the following committee was appointed to draw a vital statistics bill. E. J. Lutz, B. M. Barnett and R. A. Roberts.

Iola was selected as the next place of meeting, but a motion was adopted instructing the council to investigate the hotel facilities, and if found to be insufficient to accommodate the meeting, they are authorized to select another place of meeting.

The house of delegates adjourned and the secretary reported the proceedings of that body to the society in regular session, after which the president introduced the president elect.

Dr. Uhls: I would like at this time to present to you your new president, Dr. J. E. Sawtell. Members of the Kansas Medical Society, I take pleasure in presenting to you a man whom you know very well, whom you have just elected to this responsible position. I bespeak for my successor the kind treatment that has been given to me.

Dr. Sawtell: Mr. President and members of the Kansas Medical Society; at this hour, I will not take up any time to make lengthy remarks; but, ungrateful indeed would be the man who under such circumstances would not attempt in some manner to voice the appreciation he ought to feel. When I say from the depths of my heart that I do appreciate the honor that this society has done me, you have but empty words as evidence. I hope during the next year to show you that I have the welfare of this association at heart. May I be pardoned for quoting just a few words from Hamlet?

“Hamlet: Good my lord, will you see the players well bestowed?

Polonius: My lord I will use them according to their desert.

Hamlet: Odd's bodkin, man, much better; Use every man after his desert and who shall 'scape a whipping? Use them after your own honor and dignity; the less they deserve, the more merit in your bounty."

I can say to the members of this association that you have treated me better than I deserve, for the less I deserve, the more merit is in your treatment. Since I have no gold to give, I give you the love of my heart and say: Make me worthy of my friends!

The scientific part of the work was carried out strictly as arranged for in the program, and the papers and discussions will be published from month to month with each issue of the Journal.

CHAS. S. HUFFMAN, Secretary.

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SOCIETY NEWS.

REPUBLIC COUNY.—The Republic County Medical Society met at Scandia, May 21, 1907 and the following program was carried out:

"Electro-Therapeutics," Dr. J. C. Decker of Belleville.

"A Case of Pneumonia," by Dr. J. S. Billingsby, Belleville.

"Some Obstetrical Data," Dr. Wm. Kamp, Belleville.

"Psycho-Therapy" by Dr. C. V. Haggman, Scandiia, Kan.

The attendance was fair and the interest good. All the papers were well written and thoroughly discussed. Two new members were admitted to the society, and all present declared it was an afternoon and evening well spent.

JAY C. DECKER, M. D., Secretary, Belleville, Ks.

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Editor Journal of Kansas State Medical Society, Columbus, Kans.

Dear Sir:—April 26th the Reno County Medical Society entertained the county societies of Southwest Kansas. Sixty-eight doctors attended the day meeting, which consisted of an all day meeting, program of which I enclose. Papers were all good and all visitors felt at home and took a lively interest in the discussion, thus bringing out many points of interest to all. Near the close of the session Dr. M. T. Basketh presented a clinic. After a heated discussion for nearly one hour a vote was taken and the majority declaring it a case of Psoriasis. In the evening the visiting doctors were given an automobile ride over town; this followed by a banquet at the Santa Fe Hotel. Thirty-eight physicians remained for

the banquet. The menu was an elegant one and the banquet was served with the promptness and perfection characteristic of the Harvey hotel people. When the last course was served Dr. S. M. Callady took the toastmaster's station and for two hours the gentlemen around the table enjoyed witty remarks, humorous anecdotes and interesting experiences as told by the doctors and their guests.

The toasts were responded to as follows:

"The profession of medicine as a moral teacher," Rev. Elmer Ward Cole.

"Reminiscence," Dr. H. S. Justice.

"The doctor and the newspaper man," W. Y. Morgan.

"Studying in Vienna," Dr. Meade.

"The physician from a legal standpoint," J. M. Brown.

DeWelsh, president of the Reno County Society, spoke of the pleasure the home physicians felt in the occasion and announced that the Southwest Kansas Societies were invited to come back to Hutchinson next year for another meeting. The announcement was greeted with enthusiastic applause, showing the agreement of the sentiments expressed by Dr. Uhls. Dr. Callady closed the evening's program with an expression of gratification at the number of guests, the interest taken and the promise for the future in bettering acquaintance and knowledge among the profession in the southwest.

From the out of town physicians there was but one story: of a successful, enjoyable meeting and a delightful entertainment. The papers on professional subjects had been carefully prepared and were of advantage to all, and the general interchange of ideas and views could not be but beneficial.

The meeting far exceeded the expectations of the local physicians. The scientific session was held at the commercial club rooms, and there was too little time to entirely finish the program prepared.

W. F. SCHOOR, Secretary.

PROCEEDINGS FOR ORGANIZATION OF WOODSON COUNTY MEDICAL SOCIETY.

The following legally qualified physicians of Woodson county, Kansas, viz: D. W. Maxson of Toronto, Kan., M. D. Elder of Piqua, Kan., H. W. West, E. K. Kellenberger and B. F. Browning of Yates Center, Kans., S. J. Bacon of Yates Center, Kans., Dr. G. W. Lee of Toronto, Kans., and A. J. Lieurance of Neosho Falls, Kans., met at Yates Center, Kans., and on motion, Dr. D. W. Maxson was elected

temporary chairman. Dr. E. K. Kellenberger temporary secretary.

On motion it was unanimously carried that the following constitution be adopted as the constitution of the society.

[Constitution as published by the press of American Medical Association for county societies:]

After the adoption of the constitution and signing thereof, proceeded to the election of officers.

Dr. D. W. Maxson of Toronto elected President.

Dr. H. W. West, Yates Center, elected Vice-president.

Dr. E. K. Kellenberger, Yates Center, Secretary and Treasurer.

For Censors the following were elected: Dr. M. D. Elder for 3 year term; Dr. B. F. Browning, 2 year term; Dr. H. W. West, 1 year term.

Dr. G. W. Lee of Toronto, Kans., was elected delegate to Kansas Medical Society. Dr. H. W. West elected alternate.

On motion the president appointed Drs. E. K. Kellenberger, H. W. West and B. F. Browning committee on by-laws to report first Tuesday in June, 1907, 8 p. m.

The following resolution was unanimously carried: "Resolved, the Council of Kansas Medical Society be requested to grant a charter to Woodson County Medical Society."

It was ordered that the secretary present the proceedings of this temporary organization to the District Councilor of Kansas Medical Society and ask that they be made permanent.

On motion the society adjourned to meet on first Tuesday in June, 1907, at 8 p. m. at Dr. H. W. West's office in Yates Center, Kans., to receive report of committee on by-laws and transact such other business as may be presented.

On the 30th day of April, 1907 at 2 p. m. pursuant to notice of meeting called by District Councilor M. F. Jarrett, M. D., the following legally qualified physicians of Woodson County, Kans. met in the parlor of Woodson Hotel, Yates Center, Kansas. Dr. M. D. Elder, Piqua, Kans., Dr. G. W. Lee, Toronto, Kans., Dr. A. J. Lieurance, Neosho Falls, Kans., (by proxy), Dr. H. W. West, Yates Center, Kans., Dr. E. K. Kellenberger, Yates Center, Kans., Dr. S. J. Bacon, Yates Center, Kans., Dr. B. F. Browning, Yates Center, Kans., Dr. D. W. Maxson, Toronto, Kans., (by proxy). With the following visitors present: Dr. C. W. Rennick of Gas, Kans., Dr. P. S. Mitchell, Dpt. Councilor, Iola, Kans., Dr. Bolton, Iola, Kans., Dr. F. H. Martin, Iola, Kans.

The meeting was called to order by Deputy Councilor P. S. Mitchell. After stating the objects of the meeting and advantages

of county societies, etc., he declared it open for transaction of business. Dr. E. K. Kellenberger then presented and read the proceedings of temporary organization of the physicians above stated and made a motion that they be adopted and the temporary organization made permanent, which was seconded and after brief discussion adopted without dissenting vote.

I herewith certify that the above proceedings were adopted without dissenting voice and the temporary organization was made permanent. (Signed) P. S. MITCHELL, Dep't. Consular.

Yates Center, Kans., April 3, 1907.

Dr. H. W. West, vice-president, was called to the chair. After short talks between visiting and resident members, on motion the Woodson County Medical Society adjourned to meet Tuesday evening June 4, 1907 at 8 p. m. at Dr. West's office, Yates Center, Kan.

W. H. WEST, President.

E. K. KELLENBERGER, Secretary.

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NEWS AND NOTES.

Rosedale Kansas, May 1, 1907.

Dr. C. F. Taylor, 1520 Chestnut St., Philadelphia.

Dear Doctor:—The marked copy of the May Medical World has just reached me. This attack on the organization press is of course what I have been expecting for some time. The independent medical press affords a livelihood to too many aggressive men for such a movement as that represented by modern organization to escape without a protest from its control.

I think that you do not realize that there is a fundamental difference between the editors of the association journals and your editors of independent journals. In the first place, the editors of the association journals are elected and are very liable to lose their positions at any meeting of the state associations. But the "independent" editor owns his journal. Secondly, they are not paid for their services and therefore cannot afford to go to any great expense in attending the meetings or paying the dues of an organization devoted purely to the consideration of medical journalism—as long as they do not expect to make it a life study. The "independent" editors, on the other hand, are making their living from their editorial work. Thirdly, their work is different from that of the independent journal. The independent editor should conduct a medical newspaper, or else studies for specialists. He should bring to his readers the medical news of the whole world and make a spe-

cial point in discussing the advance in medicine, both as a science and art; while the organization editor is conducting a campaign for the elevation of the medical profession in his particular territory. His work, therefore, is chiefly to get the men of his territory acquainted with each other, discuss their particular problems, and work in general on the psychological side of professional life. For this reason, the problems confronting the organization editors are quite distinct from those confronting the independent journalists; and, it is practically absolutely necessary for them, if they join any organizations at all, to have special organizations of those who meet similar problems.

In view of these facts, you will readily understand that I believe there is a necessity for both independent and organization journals. The two must work as complements, not as competitors. And in order to enable the present association to meet the demands of the organization press, it must assume a different standpoint than that of financial success.

I attended part of the Atlantic City meeting of the association of medical editors, and had the pleasure of attending your banquet and seeing and meeting many of your colleagues. I enjoyed this meeting very much; and, would probably have become a member of your organization had I felt that my work as editor would continue for any considerable time. I am now at liberty to say these things to you, because I am no longer editor of the Journal of the Kansas Medical Society and therefore, speak from an independent standpoint.

Very truly yours,

G. H. HOXIE.

THE OPSONIC INDEX.—A good idea of the technique for making this study of your patient's condition can be obtained from the articles by Houghton and Miller in the Therapeutic Gazette for January 15 and March 15, 1907. A reprint of these articles can be obtained gratis from Parke, Davis & Co., Detroit, Mich. We believe that the study of opsonis will prove of great value to the profession. Dr. Brewster, a K. U. graduate, has just gone over to London to make there with Wright, the originator of the method, a four months study of the technique. Dr. Brewster will then demonstrate the work to the Clinical Department of the School of Medicine of the University of Kansas.

Treasury Department, Bureau of Public Health and Marine-Hospital Service,
Washington, D. C., May 17, 1907.

A board of officers will be convened to meet at the Bureau of

Public Health and Marine-Hospital Service, 3 B street SE., Washington, D. C., Monday, July 15, 1907, at 10 o'clock a. m., for the purpose of examining candidates for admission to the grade of assistant surgeon in the Public Health and Marine-Hospital Service.

Candidates must be between 22 and 30 years of age, graduates of a reputable medical college, and must furnish testimonials from responsible persons as to their professional and moral character.

The following is the usual order of the examinations: 1, physical; 2, oral; 3, written; 4, clinical.

In addition to the physical examination, candidates are required to certify that they believe themselves free from any ailment which would disqualify them for service in any climate.

The examinations are chiefly in writing, and begin with a short autobiography of the candidate. The remainder of the written exercise consists in examination of the various branches of medicine, surgery and hygiene.

The oral examination includes subjects of preliminary education, history, literature and natural science.

The clinical examination is conducted at a hospital, and when practicable, candidates are required to perform surgical operations on a cadaver.

Successful candidates will be numbered according to their attainments on examination, and will be commissioned in the same order as vacancies occur.

Upon appointment the young officers are, as a rule, first assigned to duty at one of the large hospitals, as at Boston, New York, New Orleans, Chicago or San Francisco.

After five years service, assistant surgeons are entitled to examination for promotion to the grade of passed assistant surgeon.

Promotion to the grade of surgeon is made according to seniority, and after due examination as vacancies occur in that grade.

Assistant surgeons receive \$1,600, passed assistant surgeons \$2,000, and surgeons \$2,500 a year. When quarters are not provided, commutation at the rate of thirty, forty, and fifty dollars a month, according to grade, is allowed.

All grades above that of assistant surgeon receive longevity pay, 10 per cent in addition to the regular salary for every five years' service up to 40 per cent. after twenty years' service.

The tenure of office is permanent. Officers traveling under orders are allowed actual expenses.

For further information, or for invitation to appear before the board of examiners, address "Surgeon-General, Public Health and Marine-Hospital Service, Washington, D. C."

THAT FAMOUS CROWBAR CASE.

Dr. John M. Harlow, one of the oldest and most prominent physicians and surgeons in New England died May 13, 1907 at his home in Woburn, Mass., aged 87. He was born in Whitehall, November 25, 1819. He attended the Methodist Collegiate institute at West Poultney, Vt., and the academy at Ashby, Mass., where he later became assistant principal. In 1840 he began the study of medicine at Jefferson Medical school in Philadelphia, from which he was graduated in 1844. In 1845 he began practice in Cavendish, Vt., where he remained for fifteen years. It was while at that place that he performed his remarkable cure of a usually fatal wound of the brain which gave him world-wide fame among medical men. A young man who was drilling a hole in a rock had an iron bar 3 feet 7 inches long blown through his skull by the premature discharge of a blast. When the accident took place the man was holding the bar in his hands. The explosion drove the bar completely through his head and high in the air. Fortunately the bar was round and smooth by use. The accident occurred on September 13, 1848, and the victim of the accident lived as late as May 21, 1861, when he died in San Francisco. Dr. Harlow published an account of this remarkable case, entitled "Recovery from the passage of an iron bar through the head," and skull and bar are now in the exhibition of the new Harvard Medical school in Boston. Returning to Philadelphia Dr. Harlow passed nearly three years in travel and study and resumed practice in Woburn in the autumn of 1861.

A NEW BILL IN NEW YORK.

Albany, May 14.—Governor Hughes last night signed the bill of Assembly committee on public health, revolutionizing the system of state control of the practice of medicine, known as the "medical unification" bill. It creates a new definition of the practice of medicine, more sweeping than the old, and substitutes one board of medical examiners under the auspices of the board of regents in place of the three boards now having jurisdiction, and representing the allopathic, homeopathic and eclectic medical societies. The new law recognizes osteopathy as a system of treatment, and provides for examination and licensing of its practitioners.

The practice of medicine is defined as follows: A person practices medicine within the meaning of this act, except hereinafter stated, who holds himself as being able to diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity or physical condition, and who shall either offer or undertake, by any

means or method, to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical condition."

Among the exceptions from the application of the law is "the practice of the religious tenets of any church," which will apparently exempt practitioners of Christian Science.

Under the provisions of the new law, "there is to be a state board of medical examiners of nine members appointed by the regents, to hold office for three years from August 1 of the year in which appointed. In constituting the first board, the regents are to designate three members to serve for one year, three to serve two years and three to serve three years from August 1, 1907." Thereafter three members are to be appointed annually for three years each.

Of osteopaths the law says: "Where the application be for a license to practice osteopathy, the applicant shall produce evidence that he has studied osteopathy not less than three years, including three satisfactory courses of not less than nine calendar months each in the three different calendar years in a college of osteopathy maintaining at the time a standard satisfactory to the regents. After 1910 the applicant for a license to practice under this act shall produce evidence that he has studied not less than four years, including four satisfactory courses of not less than seven months each in four different calendar years in a college maintaining at the time a standard, satisfactory to the regents."

POWDER BURN OF FACE.

By E. Kuder, M. D., Coffeyville, Kan.

About a year ago I was called in a hurry to relieve the awful suffering of Carl Rucker, of this city, 10 years old, who, when playing with other boys, exploded about two ounces of coarse black shooting powder in a little earth mound, and not being quick enough to turn away got the most of the discharge into his face; even the conjunctiva of both eyes were blackened, and from the burn and subsequent inflammation shut tight; one of the ears also got burned very badly.

To extract the powder from the skin I have in years gone by, applied a thick layer of castile soap made into a sort of dough, and as I had to deal here with the inflammation and pain beside, I scraped a cake of shaving soap, mixed it thoroughly with antiphlogistine, and applied it about one half inch thick all over the face and ear, leaving a hole for eyes, nostrils and mouth. About one-half hour later the little patient, a very sensible child, rested very

comfortable, free from pain and slept a few hours soundly. About 24 hours later I removed the whole mask from the boy's face and to my great delight and surprise the application had drawn out every kernel of the powder. The inflammation had been greatly reduced, pain was all gone and the face appeared almost natural again with the exception of the sclera of both eyes, which I treated with a solution of cocaine adrenalin.

Another remarkable circumstance is the fact that the boy at the same time got entirely rid of his freckles, not a trace of the latter could be detected.

For about a week the face got anointed with cold cream twice daily, and being well was discharged as cured.

THE MEDICAL INSPECTION OF SCHOOLS.

St. Louis Courier of Medicine.

It will not be long until the state will look after the health and physical development of children as well as their intellectual growth. The practical results in New York are astounding, and it is inconceivable how those in charge of our municipal school systems can neglect the institution of those methods which promise so much to the physical welfare of the younger generation. Prophylaxis is the guiding principle everywhere and the time is not far distant when the acute contagious diseases will be, like smallpox, among the rarer epidemics. What terrible neglect it is to allow a child with nasal diphtheria, for example, to attend school a week or more before he is isolated! Why should the child be tortured with prolonged daily study, who has a defect in vision or hearing?

The function of school inspection has been well stated by Lovett: First, to detect infectious diseases in its early stage, thus cutting down the danger of contagion; second, to detect and cure or provide for defective children; third, to improve school conditions.

What infectious diseases should be included under the contagious diseases necessary for isolation? Upon a few all are agreed, but there are others—the acute respiratory infections, for example—to which serious objections might be offered, if no attempt be made to place them in the class which needs isolation.

No doubt, this problem will be gradually solved, but there is already enough work so that the organization of municipal medical inspection of schools can be commenced at once.

Dr. F. A. Carmichael of Goodland and Miss Rose May McCloskey of San Antonio, Texas, were married at the home of the bride May 15, 1907. The Journal extends congratulations and best wishes for future happiness.

ABSTRACTS.**THE STANDARDIZATION OF THE CARDIAC REMEDIES.**

C. W. Edmunds, Ann Arbor, Mich. (Journal I. M. A., May 25), gives the result of his examinations of a number of samples of tinctures of digitalis and strophanthus on the market in different parts of the country, with a view of ascertaining the relative strength of the different preparations which are sold under the same name. The test method chosen by him was that of ascertaining the dose needed to produce the stand-still of the frog's heart, due allowance being made for difference in size of the frogs, and care being taken that they are all of the same species. Occasionally there is a frog more susceptible or more tolerant than the rest, and this also has to be allowed for, and a larger number injected to avoid error. The details of the method and the dilutions of the drugs employed are given. Fourteen different tinctures of digitals obtained from wholesale manufacturers and retail pharmacists, and made in the laboratory, were tested and were found to vary extensively, some of the preparations being nearly four times the strength of others, even when obtained from the same source. The strength of the dose the patient receives would seem, therefore, to be a matter of luck. A laboratory-made infusion of digitalis prepared from the same leaves as one of the tinctures tested was found to have an effect on the heart proportionate to the strength of the preparation. Five samples of tincture of strophanthus, obtained from wholesale manufacturers and advertised as physiologically assayed, were also tested, and like variations in effectiveness found. The need of some kind of a national standard is emphasized by the experiments. At present, the physiologic assay is made by the physician at the bedside. He watches the effect of the dose given and alters it till it meets the requirements. A proper standardization would shorten this process if it did not do away with it altogether, and would save valuable time which may mean the difference between life and death to the patient.

ISOPRAL AND HYDRATED CHLORAL.

R. A. Hatcher, New York City (Journal A. M. A., June 1), has experimented with isopral, advertised as the safe hypnotic of the chloral group, acting "more efficiently than chloral in one half the dose and without depressing effects on the heart and nervous system." He criticizes the statement and figures of Impens, who made the margin of safety for isopral about three and a half times that of chloral in the case of cats, and shows by his experiments on

these same animals that it is less efficient as a hypnotic and even more toxic in the same dose. Furthermore, sublethal doses of isopral cause profound depression of the respiratory center and more lasting inco-ordination than does hydrated chloral in like doses. A number of experiments were also made on dogs with a view to determining the relative effects of isopral and chloral on the respiratory and vasomotor centers. He found that 0.1 gram of isopral per kg. of body weight caused a much greater fall in blood pressure (vasomotor depression), and a more profound depression of the respiratory center than did twice as much hydrated chloral, three times as much hydrated chloral as isopral being required to produce paralysis of the respiratory center; the vasomotor center was less affected after hydrated chloral than after isopral, as indicated by the asphyxial rise occurring after chloral, but not after isopral. From Hatcher's own experiments on rabbits, made before reading Impen's paper, he had concluded that 25 parts of isopral equalled in hypnotic effectiveness and toxicity 40 parts of hydrated chloral in these animals. This would make the maximum dose of 2.5 grams isopral, used by Wassermeyer, a very unsafe one. In conclusion, Hatcher expresses his belief that his experiments on rabbits and cats and Impen's experiments on rabbits show that there is no essential difference between isopral and hydrated chloral in effective doses on the respiratory centers, while his own experiments on dogs show that isopral is more than twice as active in depressing the vasomotor and respiratory centers and the heart. Cautious clinicians, he says, will not experiment with isopral except in carefully selected cases. It seems almost superfluous, he states, to add that isopral, like chloral, is wholly unsuited for use in cases in which sleeplessness is due to pain, since it is an anesthetic only in extremely dangerous doses.

BIMANUAL VIBRATORY PALPATION.

H. A. Kelly, Baltimore (Journal A. M. A., June 1), finds that the difficulties of accurately outlining a kidney or uterine or ovarian tumor can be overcome by using what he calls vibratory palpation. In the case of a pelvic tumor, for example, the finger in the vagina rests lightly on the cervix, if it is uterine, or on its lower pole if it is ovarian. Then the upper hand plays lightly over the abdominal wall, over the tumor, touching first its central portions and then advancing rapidly out toward its periphery, in all directions, communicating a series of very rapid light vertical succession movements. These little vibrating thrills are felt very distinctly by the

finger in the vagina as long as the tumor is played on, and are lost as soon as the vibrations fall on the intestines or fat abdominal wall just beyond the edge of the growth. The vibrations are communicated by giving from three to five little tremulous movements every second to the palpating fingers. The actual to and fro movement need not extend over one centimeter. In this way an accurate outline of the tumor and its irregularities can be obtained.

THE COMMERCIAL DOMINATION OF THERAPEUTICS AND THE MOVEMENT FOR REFORM.

G. H. Simmons, Chicago (Journal A. M. A., May 18), gives a history of the fight of the medical profession against the commercial domination of therapeutics, an evil that has become more than ever dominant during the past thirty years, which has demoralized our advertising literature, checked advance in scientific methods of treatment, inhibited intelligent clinical observation, debauched medical journalism and tainted even our text-books. In the early days of medicine in this country, the evil was not in proprietary drugs, but in the poor quality and unreliability of medicines. Hence the adoption of the Pharmacopeia, which being only advisory, only partially bettered the situation, and the question was still a vital one during the earlier history of the American Medical Association. In 1879 we first find the Association recognizing the incipient evil of modern proprietary medicines, and from this time on we find this subject more or less a subject of discussion in its meetings until, with the founding of The Journal, it became, on account of the advertisements, a very practical question. The problem was one that could not be solved by the physician alone, the co-operation of the pharmacist was essential, and under the existing conditions the two professions had been drifting apart. In recognition of this fact, a series of articles by a leading pharmacist appeared in The Journal in 1900 on "The Relation of Pharmacy to the Medical Profession," and the remedy was suggested. It was not, however, until 1904, that the matter was formally introduced at the session of the Association; it was acted on the following year and the council on pharmacy and chemistry held its first regular session in Pittsburg, Feb. 11, 1905. At that meeting rules were adopted which should govern the council in deciding whether or not a preparation should be accepted as ethical and proper to be used by the physician. These rules are explained in detail. Rule 4, against preparations indirectly advertised to the public, threw out at once without any further labor, at least three-fourths of the proprietary medicines on

the market, and the rule against secrecy, extravagant claims, misleading statements, unlabeled poisons, objectionably suggestive names, etc., explain themselves and show the standard adopted for an "ethical" proprietary medicine. The method of procedure of the council is described and its position as regards approval of preparations stated. The reason for the inclusion of drugs in the proposed work, "New and Non-Official Remedies," are given in full. Co-operation of workers in this country and abroad has been secured and its advantages are obvious. The work has been going on now for a little over two years, and, while advertising seems still active and nostrums are still numerous on the market, its effects are to be seen in the fewer write-ups of proprietaries, the falling off in the sales of typical nostrums, a fact well-known in the trade, a withdrawal of many specialties, and less extravagance in descriptions and claims. Only a part of this can be credited to the national Food and Drugs Act. The process had already begun before it was passed. The knowledge that the medical profession is at last awake greatly aids the influence of the council, which is more extensive than will ever be known. The council is a purely advisory body, it has no power to force its rules on manufacturers. What it asks is the support of the medical profession and this must be an active, not a negative support.

AMPUTATION OF THE THIGH UNDER HYOSCINE-MORPHINE-CACTIN ANESTHESIA.

By Henry G. Ebert, M. D., Assistant Surgeon in the Public Health and Marine Hospital Service.

I wish to report the successful use of the hyoscine, morphine and cactin combination as a general anesthetic in an amputation of the thigh in the upper one third.

The tablets used were those put up by the Abbott Alkaloidal Company, and contained Hyoscine Hydrobromide, gr. 1-100, Morphine Hydrobromide, gr. $\frac{1}{4}$, Cactin gr. 1-67, Injections (hypodermic) were given two hours, one hour and half an hour before operation. Anesthesia was ideal and complete throughout operation and for several hours afterward. No ill effects whatever were noticed at any time. Muscular relaxation was not so complete as in ether or chloroform anesthesia so that after the operation no subsequent contraction of flaps took place and there was no more tension on the stitches afterward than at the time they were put in.

If this anesthetic will work in all cases as well as it did in this and numerous others reported in the medical journals, it would ap-

pear to be the ideal anesthetic for field use and emergency work where one may be short handed, as it does away entirely with the anesthetist and the space and care necessary in the transportation of ether or chloroform.

The absence of inconvenient after-effects is a most valuable feature of this preparation in field work, while the ability to perform serious operations promptly is of particular advantage; but of equal utility in active service is the possibility of securing complete rest and anesthesia in cases of injuries too extensive to permit of immediate operative attention, such as in visceral injuries of the abdomen, chest or head. It seems a good thing for the military surgeon and should come into favor with him.

COMMENT NOTE.—It would seem that if such operations as described could be performed successfully, this anesthetic could be used to great advantage in railroad wrecks, fires, etc., where a number of people are injured.

THE MEDICAL ERA'S SPECIAL EDITIONS.

The Medical Era of St. Louis, Missouri, will conform to its usual custom and issue its yearly series of special Gastro-Intestinal numbers embracing July and August. The August issue will be given over entirely to the consideration of every phase of typhoid fever. The series will contain about 35 or 40 practical papers and will contain a large amount of valuable information.

BOOK REVIEW.

BOOK REVIEW: A text book of the practice of medicine for students and practitioners, by Hobart Amory Hare, M. D., B. Sc., Professor of Therapeutics in Jefferson Medical College of Philadelphia, Editor of Therapeutic Gazette, etc. Second Edition, revised and enlarged. Royal octavo, pg. 1132 with 131 engravings and 11 plates. Philadelphia, 1907, Lea Brothers & Co.

This is a beautifully gotten up book. The work of the publisher and editor appears faultless. The diction is clear and easy, the style simple. If we might be permitted here to summarize briefly our opinion of the book, we would state that it is an excellent primer for that class of students that is being trained by the lecture and recitation as opposed to the laboratory method of instruction.

Since Hare is primarily a therapeutic specialist, we find only summaries and reviews on the matter of etiology and pathology. His work in therapeutics is of the generalizing and empirical type

rather than that of the experimentalist in the laboratory and at the bedside.

The book meets of course the needs of a large class of physicians who wish summaries rather than the results of personal studies, and for this purpose it has a legitimate field.

BOOK REVIEW: *The essentials of Histology—Descriptive and practical for the use of students* by E. A. Schafer, L. L. D., Sc. D., F. R. S., Professor of Physiology in the University of Edinburg, Seventh Edition Octavo, pg., 507, with 553 illustrations. Phidelphia, 1907, Lea Brothers & Co.

This text is intended for use in laboratories, but gives also some discussion of the matters of histology so that it may be used for review and study at home. It is essentially therefore a textbook, rather than a monograph for the research library.

We like the illustrations—especially those made by halftones of drawings. Some of the more diagrammatic drawings are printed in colors in the effort to reproduce the effect of the microscopic slide. This is helpful to the laboratory student especially when he has at hand some one to interpret such illustrations and slide-pictures.

The course consists of fifty lessons each requiring from one to three hours of work. This compares well with the work of the ordinary medical schools, tho the University of Kansas gives ninety periods of two hours to the subject.

Prof. Schafer's statements are dogmatic, even on matters where others hold a different opinion. This, of course, weakens a laboratory manual, in that it does not lead the students to become their own judges.

A Manual of Obstetrics.—By A. F. A. King, M. D., Professor of Obstetrics and Diseases of Women in the Medical Department of the George Washington University, Washington, D. C., and in the Medical department of the University of Vermont, etc. Tenth edition, enlarged and thoroughly revised. 2mn., 688 pages, with 30 illustrations and three colored plates. Cloth. Price 2.75, net. Lea Brothers & Co., Philadelphia and New York, 1907.

One has but to turn over a few leaves the new tenth edition of King's obstetrics to realize that he is opening an old and tried textbook. The information is encyclopediac in character, but so condensed that one has no sense of verbosity or of wasted time. Evidences that the book has lived thru many changes in medical opinion is furnished by statements similar to the following: "Women predisposed to phthisis should be advised not to marry, as well for their own sake as for that of their progeny, who may inherit the disease, and that of their husbands, who may contract it by infec-

tion." We hardly believe in the heredity of tuberculosis now, although we do believe in the general sentiment expressed by the sentence as a whole.

The illustrations are in the main etching and not equal to the half tone reproductions of photographs that appear in the newer text-books. Nevertheless, they appear to be adequate.

In our humble opinion, students trained on King will have a firmer grasp of essentials than those who have to wade through more voluminous but also more one-sided text-books.

BOOK REVIEW: *Physical diagnosis with case examples of the induction method*, by Howard S. Andrews, M. D., Professor of physical diagnosis in the Medico-Chirurgical College of Philadelphia. Cloth, Royal 8vo; pg 456; 32 plate, 88 textual illustrations. New York, 1907. S. D. Appleton & Company.

From the preface of this book we understand that it is intended primarily for junior students who are just taking up the subject of physical diagnosis. In the hands of a competent instructor who is ready to furnish a great many illustrations and details not given by the book, the text may prove of value.

The case examples consist of three on lung diseases and three on heart diseases, and are, as far as they go, very valuable. It seems to us that had he put in at least 25 more such cases, the author would have made his book distinctively valuable. As it is now we fear that his number of case histories is not sufficient to make the book more valuable than a copy of some such publication as *The Medical World* would be with its case histories.

On the subject of blood pressure, we note that Professor Anders does not give us the method of taking the diastolic blood pressure; nor, in fact, does he give us sufficient detailed instruction of the method to make his reference to it of any particular value.

In general, the work leaves us with the impression of being written in too great haste and too carelessly to meet the needs of those who seek a text-book on physical diagnosis.

THE JOURNAL OF THE OFFICER'S REPORTS.

SECRETARY'S REPORT.

I respectfully submit the following report to the house of delegates for the year ending, May 1, 1907:

In most of the organized districts and counties, the usual good interest is maintained. Since making my report last year, three counties have been organized, namely: Lincoln, in the eighth district Chautauqua, in the fourth, and Woodson, in the second. There are two counties in the eastern or populous part of the state, that have not become identified with the state society—Franklin and Morris. Franklin has an organization but Morris is not organized. We hope to get these two counties in the fold soon. There are several counties in the eighth district, that have sufficient population to maintain good county societies, or multiple county societies. I refer to Ellsworth, Russell and Ellis counties. The organization as it now stands is as follows:

Total number of county and multiple county societies	67
Total number of counties organized	97
Total number of counties not organized	8
Total number who have paid dues for 1907	850
Total membership on books of society	1218

At the meeting of the council on Feb. 5, 1907, at Topeka, Dr. G. H. Hoxie, tendered his resignation as Editor of the Journal of the Kansas Medical Society. The council decided to combine the work of the secretary and editor, and appointed your secretary to be editor for the next year. Some complaint has been made by members that they have not received the Journal. It is to be hoped that we can keep the mailing list so carefully revised that no trouble of this kind will occur during the ensuing year. The secretaries of all county societies are earnestly requested to notify the state secretary at once of any change in the residence, or removal from state, of any members, also be careful and write the name plainly, and spell it correctly. This alone will save much correspondence.

Any members not receiving The Journal will please write to the editor, and the matter will receive prompt attention.

All dues should be paid as soon as possible after January of each year. This will give the secretary time to give all proper credit and send them their membership cards early in the year. The

constitution provides that if all dues are not paid by April 1 of each year, those not paying shall be dropped. The council has been lenient in this respect and has only dropped those who were recommended to be dropped by the officers of their county society.

Dr. M. F. Jarrett was appointed a delegate, by President Uhls, to attend the meeting of the Council of Medical Education of the A. M. A., which held its annual conference in Chicago, April 29, 1907. His report will be appended to this report.

A communication was received from a representative of the Iowa State Medical Society, asking if our state society had taken any steps toward adopting some plan to defend members who have malpractice suits on their hands. I simply call your attention to this communication, without any recommendation, and your body can take such action as they deem best.

I would like to call the attention of the delegates to the importance of having the county secretaries to make prompt reports of deaths of members, to the state secretary, that such notices may be given suitable recognition in The Journal.

FINANCIAL REPORT.

Amount of dues collected during the past year.....	\$1,988.20	
Amount turned over to Dr. L. H. Munn, treasurer.....		\$1,988.20
Amount in Dr. L. H. Munn's hands at last report		3,382.71
Total.....		5,370.91
Amount paid out on warrants.....		1,317.86
Balance in hands of treasurer.....		4,053.05

Respectfully submitted,

CHAS. S. HUFFMAN, Secretary.

TREASURER'S REPORT.

Mr. President and Fellows of the Kansas State Medical Society. I have the honor to submit the following report:

Cash on hand May 7, 1906.....	\$3,382.71
Cash received from Chas. Huffman, secretary, from July 9, 1906, to May 6, 1907	1,988.20
Total	\$5,370.91
Cash paid out by order of President and Secretary.....	1,317.86
Leaving a balance in treasury May 7, 1907.....	\$4,053.05

\$100.00 was advanced to the editor of The Journal. I hold his note for this amount, which I anticipate will be returned to the Society.

Respectfully,

L. H. MUNN, Treasurer.

EDITOR'S REPORT.

JOURNAL REPORT—CASH RECEIPTS.

Cash on hand May 1, 1906	\$ 77.84
Advertising receipts	1,321.56
Subscription receipts	22.00
Miscellaneous receipts	23.73
Loan Kansas Medical Society	100.00
Loan G. H. Hoxie	178.68
	<hr/>
	\$1,723.81

JOURNAL EXPENSES—SUMMARY.

Itemized account	\$1,713.81
Gazette overcharge	7.80
Express on constitutions .....	.50
	<hr/>
	1,722.81
Post office charge for removing constitutions from envelopes . . .	1.70
	<hr/>
	1,723.81

Kansas City, Kansas, May 9, 1907.

To the Kansas Medical Society:

We, your committee to whom was submitted the reports of your Secretary, Treasurer, and Editor, have examined the same and find them correct.

Respectfully submitted,

M. C. PORTER,
R. A. ROBERTS,
Auditing Committee.

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THE JOURNAL

OF

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***PUERPERAL INFECTION.**

It may be said by someone present that this is a hackneyed subject, that it has been threshed out, over and over, and so it has, and every time we take the subject up we find more of the golden grain in the straw than has ever been taken out.

The fact that the most accurate statistics obtainable reveal to us the startling information that more than 6,000 women die annually in the United States with Puerperal Infection, and more than twice this number are left to eke out a life of chronic invalidism; that the same statistics show that of every 200 women who become pregnant, at least one dies of puerperal infection; that seven per cent. of the deaths of women between the ages of twenty and forty years are due to puerperal infection, and we glean from the same source of information that ninety-five per cent. of these deaths occur in private practice; that in well conducted hospitals, puerperal infection is almost unknown, save an occasional case where the patient was infected before entering the hospital. This array of facts affords strong argument in favor of threshing over again this subject. Just so long as this dread disease continues to claim as its victims our wives, mothers, sisters and daughters, just so long it will continue to be a subject for discussion in our medical societies. It was in 1843 that Oliver Wendell Holmes first sounded the key note that child-bed fever was an infectious disease, and in 1847 that Semmelweiss announced to his professional associates that the disease was infectious. When we are reminded that for more than three

*Read before the forty-first annual meeting of the Kansas Medical Society at Kansas City, May, 1907.

score years the great teachers of medicine have advocated the infectious character of puerperal fever, and that in all well conducted hospitals they have practically succeeded in stamping it out of existence, leaving ninety-five per cent. of the deaths from the disease to the credit of physicians doing a private practice, we are forced to acknowledge that we have been criminally negligent of our duty to mankind. I regret to say that little, if any, progress has been made in private practice towards stamping out this disease that is devastating so many homes. I am impelled to assert that puerperal infection is not any less frequent or virulent today in private practice than it was forty years ago. When Holmes and Semmelweiss first gave utterance to the belief that puerperal sepsis was caused by some germ or micro-organism, infectious in character, they were jeered and hooted by their professional associates. And Semmelweiss was so chagrined and grieved by the slowness of the medical profession in accepting his teaching of the infectious character of the disease, that he became insane and died in a hospital for the insane. Today no one questions the authenticity of the virulence of the streptococcus, together with its many co-workers. When they start out on their death-dealing mission, we stand aghast in their presence, well knowing and recognizing what it means to our patient. There no longer remains any ground for discussion on this point, nor need we consume any of your time in the description of these germs and cocci. All are familiar with the manner in which these organisms gain entrance into the tissues of the body and circulation, through tears and abrasions of the genital tract, and at open uterine sinuses. You ask how these organisms get into the genital tract? I would answer, almost always by the dirty hands of the accoucheur, midwife, or dirty nurse, or dirty instruments. And we would add that one of the most fruitful sources of infection, is when the assiduous doctor or nurse insists on the routine use of the vaginal douche, who resurrects from the depths of some dirty old closet, the family or neighborhood syringe, and proceeds to give a vaginal douche. Then you may expect trouble. Another potent source of infection is a relaxed, flabby, spongy uterus. Having briefly passed over this part of the subject, we may devote more time to treatment, and especially prophylaxis. It is my purpose to consider this subject as we find it in private practice, and bring it down to bottom facts, will say country practice, just as we in the country find it. I have made the sweeping assertion that we have puerperal infection just as often in private practice today, as forty years ago. I verily believe this a true statement, and have

verified it by consulting physicians of my acquaintance who have been actively engaged in practice thirty years and more, and are still so engaged. And I would ask, why should the disease occur less frequently? Our great, grand-stand play of asepsis, that we all make when we enter the lying-in chamber, washing, scrubbing, cleaning finger nails, etc., and before we reach the bed of the patient we come in contact with, and handle something that is not aseptic, the very basin we use to wash our hands, the old dirty soap dish, the family wash basin and soap are as septic as dirt and filth can make them. Nine times out of ten the water we use is far from sterile, the patient, her clothing, her bed, the room, the nurse, every assistant, and the doctor himself, ALL, are septic, then why should the disease occur less frequently? I anticipate that some one will be indignant when told that he is dirty, unclean, septic. I would urge such person to ask himself if the clothing that he has worn a year—worn that suit in all kinds of places, under all circumstances, in the barn, with diphtheria, scarlet fever—everywhere, is that suit of clothing aseptic? Forty years ago we country doctors knew very little, and thought or cared less about asepsis,—made absolutely no pretence of asepsis, and I positively assert that we had no more puerperal infection then, than now, notwithstanding the fact that in hospital practice the disease is almost unknown, while we, who are doing a private practice, are vigorously and even frantically marking time. The successful treatment of this disease must be prophylactic. That prophylaxis may be at all successful, the doctor must become fully imbued with the idea and practice of asepsis, and preach it and practice it at all times; let eternal vigilance and asepsis be his watch-word. The doctor must, by his teaching and example in the practice of asepsis, bring to his assistance the patient, the nurse, and each and every one at all associated in the care of the woman during her confinement. Without this hearty co-operation, any attempt at asepsis and prophylaxis will prove a flat failure. That such co-operation may be brought about, we must first educate the people along the lines of aseptic obstetrics,—place in their hands proper literature, teaching them the how, and the why. They must be thoroughly impressed with the importance of asepsis.

The medical profession stands today self-condemned of gross, criminal negligence, and responsible for a large per cent. of the deaths from puerperal infection,—guilty, because of neglect in not teaching the people how they may aid the physician in preventing this terrible disease. We are in need of more nurses, who are es-

pecially trained in obstetrical nursing, to take the place of the ignorant, old granny, nurses. Many are not able financially to employ a graduate trained nurse, so they are forced to take up the old granny nurse, or any one they can get. There should be some way provided that a greater number of nurses be induced to take up the vocation, and prepare themselves so as to be able to do more intelligent work. A great effort is being made, and has been pushed with vigor by state and nation, in preventing infectious and contagious diseases in man and beast, by quarantine and fumigation, vaccination, not only against smallpox, but the so-called blackleg in cattle, —much work done and expense incurred in destroying insects to save the fruit and vegetable crops, and spraying fruit trees. Should a bug or insect or aphis, or green bug be discovered, that threatens the wheat crop, Prof. Snow at once discovers a way to destroy the green bug; but here is a long line of germs, micro-organisms and cocci abroad in the land, gathering six thousand of our fair women annually, and practically nothing is being done, and many thousand learned doctors, fully knowing of their virulent and deadly character, are sitting complacently by, giving them full liberty to carry on their work of devastation.

While this great work of organizing the medical profession is going on, for the purpose of making it possible to do efficient work fighting proprietary medicines and fake nostrums, enacting Pure Food laws, etc., would it not be well for the organized profession to take up the work of educating the people along lines teaching them how they may render puerperal infection in private practice almost unknown. When it comes to treatment of septicemia, we are at sea, with a disabled rudder, and our compass badly out of order. We have no specific, and few remedies that promise any special benefit. There being no specific, we can only place each case on its merits and meet the indications. If we have any reason to suspect there are clots or fragments of placenta retained in the uterus, we should make thorough work of exploring and removing any debris. The finger is the best and safest instrument that can be used; yet there are conditions often arising that render it advisable to use a large, dull curette, bearing in mind that it is an instrument with which much harm can be done. In abortion, where the placenta is retained, I have often succeeded with the augur curette. This, too, in my opinion, is an instrument that must be used with much caution. I find a piece of gauze wrapped around an applicator, or a pair of dressing forceps, making the mop as large as can be used in the uterus freely, a good way to clear the

uterus of clots and debris, after the placental fragments have been removed; this mop should be saturated in hot, sterile water, as hot as we dare use it. We arrest the oozing of the blood and cause the uterus to contract, closing up the uterine sinuses. I am in the habit of mopping the cavity of the uterus thoroughly with carbolic acid and tincture of iodine, as the last finishing touch, applying the same liberally about the os and cervix. The uterus and vagina once thoroughly clean, and all debris and clots removed, it is advisable to meddle as little as possible with the uterus. If high temperature is a factor in the case, sponging with water cold enough to control the temperature should be used; by all means, the coal tar derivations should not be used. I am favorably impressed with colargolum by the rectum; the unguentum crede has appeared to influence some cases favorably. We must look well to sustaining the vital forces of our patient. Strychnine in full doses is a remedy of much value. Alcohols may be used with discretion; simple, easily digested, nourishing food. The excretory organs must be brought into full action, avoiding too free catharsis. The kidneys are to be brought into action, and incidentally, protected by the liberal use of water, not ice water. Our success in treating these septic patients depends solely upon our ability to recognize the special features of each case, and meet them promptly, and conserve the vital resources of the patient. With all we can do, the mortality is appalling.

G. A. BIDDLE, Emporia, Kan.

(This paper was presented by Dr. Parrington.)

DISCUSSION.

Dr. Shelley:—I am afraid that the indictment of the medical profession as mentioned by the writer of that paper is too true. My observation has been in my town—Atchison—that there are one or two deaths after confinement from puerperal sepsis each year. Of course, as a rule the doctors who have these cases are men who never attend a medical society. They consider that it is a congregation of more or less specialist who come together to impress the laity. Of course deaths from this source are not called by their name. The doctor hides the cause. I have resorted to a plan that has helped me out materially. It is to furnish every woman who applies to me to confine her, with a little pamphlet written by myself in which this is talked about. My experience is that until you educate the laity, you will not be able to accomplish much. The laity is becoming better educated. This little pamphlet is responsible for a great deal of the knowledge of this sort in my town. One woman reads of it and she tells her neighbor. Among the laymen of our town, if they happen to be where a doctor is a little careless, it is promptly referred to. It is positively wonderful how careless and indifferent a doctor may be.

Dr. Anderson:—I believe that probably puerperal sepsis is as common as it was forty years ago, but, I do not believe that it is as common following

a regular confinement as it was forty years ago. I believe that the medical profession are more careful; and, that these things are less frequent. But, if the doctors know these things and do not profit by them, why should the laity? I believe they are largely caused by abortions previously committed by men who had an illegitimate business. I have not seen a very extensive amount of work but I have failed to see one case of puerperal sepsis following a regular labor.

Dr. Langworthy—I felt very much discouraged while the essay was being read when we were informed that puerperal sepsis is as frequent as it was forty years ago. If this is the case, our efforts seem to be in vain. From experience, I can say nothing about how frequent it was forty years ago. I have no definite data from which to judge. However, from actual observation, I know that it is not nearly so frequent as it was twenty years ago. Perhaps, twenty years before that, it was worse. I am confident that a great deal has been accomplished in the last twenty years. I have no statistics; I wish I had. Death in our town from puerperal sepsis is very rare. I agree with Dr. Anderson that they are frequently brought about by abortion done in a secret way. I am glad that the doctor condemned the use of the neighborhood or family syringe. I believe a great deal of harm is done by the patient thinking she is doing a scientific thing; and using an old syringe, and thereby infecting herself. I do not expect to go into the details of this matter. I want to protest against the discouraging view that so little has been accomplished. I believe that we are accomplishing something.

Dr. Blasdel.—I enjoyed that paper. Now, last year it seemed to me that our state meeting was a meeting for the specialists. This year it is full of subjects for the general practitioner, as well as the specialist. This is a subject in which every general practitioner is interested. I know, and we all know, that puerperal sepsis occurs more frequently than it ought to occur; but, I do not believe that it occurs as frequently as it did. If it does, our teachers are at fault. Our students have been caught these things. One reason in a country practice is (I say one reason, they are numerous) that we are not called until a patient is in labor, and she is doubtless, dirty. We clean her up and leave her and see no more of her for some time. The reader said most of the cases were due to dirty fingers. A great many probably are; but, the practitioner who follows the teachings and principles that have accumulated, knows enough not to interfere. He knows enough to know a dirty finger is bad; and he knows enough to be as clean as if he were going to do a laparotomy. I believe the profession as a whole has improved. Another way that infection may take place is from internal infection—laceration of the cervix, or something of that sort. Many times we are called out; the woman is progressing when we get to the house, probably the head presenting. We are just as clean as we can be. One of the speakers said that the men who attended medical societies did not have sepsis. Well, they do. I attend medical societies and I have had cases. I believe that many of them come from internal infection. There is another point which I wish to mention. This, I think was brought out last year. Take a case where the surgeon operates on the patient. The patient may have an abdomen full of pus. The surgeon scratches his finger. The patient gets well; the surgeon dies. We should, indeed, all be very careful.

Dr. Stevens:—The probabilities are that we shall always have with us puerperal sepsis. It is my opinion that the majority of infected women in confinement is from auto-infection. It is only recently that I had a case where a woman died from puerperal fever. She had an abscess from within. I believe these things are very frequent. Dr. Shelley suggests an idea for educating the public. A great deal has been done toward educating the doctors along this line; but very little, toward educating the laity. It is the first place where I have had my attention called to where a competent person has prepared literature for the laity.

Dr. Dillon:—It seems to me that if this paper is true, it is a very serious indictment against our young physicians. It is a very serious indictment against the medical colleges today, if it is true. I have been practicing almost forty years. I do not believe that the paper (or this statement in the paper) is true. We had no reliable statistics forty years ago. Our statistics are much more complete today. I believe that we have made some advancement. We are further along than we were forty years ago. As far as the physician infecting the patient is concerned, the patient is frequently infected before the physician is called. There is another matter. I think that the patient very frequently infects herself. I suppose there are many instances where before you have fairly left the house, the woman's own fingers are in that region trying to find out what the trouble is. We have no regular trained nurses to keep things clean. Very, very frequently the patient is infected not by the physician, but by one who cares for her, or by herself. I believe that we are learning. I believe that the doctor is wrong in his statement that the percentage is as great as it was forty years ago.

Dr. Hamilton:—This subject of puerperal sepsis is very interesting to me because I have seen a number of cases—a few of my own, some of others. In looking at the cause, I have found that it is generally the fault of the physician and not of the people. The physician goes into the house. He is not as cleanly as he ought to be. He ought to scrub his hands for at least fifteen minutes and then wash them in bi-chloride solution. In that way, we will avoid puerperal sepsis a great deal. On the other hand, it is also caused by a great many (as I am unfortunately placed with foreigners now) employing midwives. They are very uncleanly and cause puerperal sepsis. Now, as to the remarks made by Dr. Shelley relating to educating the public by a pamphlet telling them what should be done: In the first place, I do not believe in educating the public in that way. I believe in telling the public what not to do instead of what to do; because, as soon as you educate the public what to do, you are going to have puerperal sepsis. They do things as they think you tell them to do them, but they do them wrong. The best thing is to tell them not to do anything; and, if nothing is done, there should be no puerperal sepsis. The uterus takes care of itself. This pamphlet would give the laity a chance to criticize the doctor. One physician may use one thing for an antiseptic; another may use another thing. We should educate the public: "Do not touch. Do not do anything." I made a rule that when I came to a case to thoroughly disinfect the parts, after washing my hands in soap and water for fifteen minutes. If there are any perineal laceration, stitch them up. It will not require any chloroform, for the parts are practically anesthetized; then wash thoroughly. To teach them to know exactly what the physician should do is to teach them

to criticize. As long as we do the right thing, it is not necessary for the laity to know just how this man proceeds to do it; or how that man proceeds.

Dr. Reynolds:—I wish to just say a word here. In connection with the education of the public: I have lived and practiced medicine before the nature of puerperal sepsis was rightly understood. I know that we were unable to protect our patients at that time through our own ignorance, more so, than we are today. It is very seldom today that we know of a case of puerperal sepsis that is fatal; and, if we do, it is generally caused not by the profession but by a midwife who is in entire ignorance of the nature of puerperal sepsis. I believe that our chief source of immunity is in educating the public. I believe that we should encourage these expectant mothers to engage a physician, not at the hour of confinement, but just as soon as they know they are pregnant. Then we should exercise a constant watch not only over the method of the preparation for confinement; but, over the general health—the action of the kidneys, especially. Make frequent urinalyses; and, keep your patient well prepared to combat anything that might arise. I practiced in the country when, if I had followed the directions to wash my hands for fifteen minutes, I should have been too late to be of use to the mother. But, if I had had charge of the mother, I should have been able to educate her to take care of herself in such a manner that even if I did not get there at all, she would be all right. After all, it is for the education of the public that we are working, for the service of the public—not for our own upbuilding.

Dr. Shannon:—A great deal of weight has been attached to unhygienic surroundings as the cause of puerperal sepsis. There is no doubt that they are a frequent cause, but I do not believe that they carry the weight that we think they do. During an interne-ship in Chicago hospital in which the out-patients numbered fifty, we had but one case of puerperal sepsis. Every precaution was used; and, this was our success. Therefore, I am inclined to believe that puerperal sepsis is caused by things coming from the outside.

Dr. Bolton:—Dr. Shannon's remark just calls to mind the statement of some of our best gynecologists and obstetricians; and that is, "Keep out of the womb." We have some physicians whom I have heard boast of the number of cases of confinement which they have waited on in one day. I have known a practitioner who in order to hurry away from the case would, in delivering the placenta, take the fingers and tear it loose and deliver in that way. There is where a large percentage of infections occur. I know of one gentleman whom I followed up in my own practice. He advised me to do that. He boasted of his success and I followed him, and tried it, and had a case of sepsis. Instead of waiting and taking more time, they make a rapid delivery and the patient winds up with infection.

Dr. Smith, Lawrence:—There is just one point that has not been mentioned—the after treatment of the patient. There are a great many physicians that as soon as the labor is over, gather up their things and leave. In cases where there is not a trained nurse, the patient is not properly cleansed. She will sometimes be left in blood and filth until there is quite a stench. I believe in many cases where we have the history of the case, we will find that the cause of puerperal sepsis will be in the after treatment.

Dr. Jones, Lawrence:—There is one point which I wish to mention.

That is, vital statistics are kept with more precision now than they used to be. Many cases of puerperal sepsis were not so-called. The lives that went out along that line were not put down as dying of puerperal sepsis. I, personally, have never known of a case of puerperal sepsis where the mother was ordinarily clean before confinement and, the physician was ordinarily careful in following out the case.

Dr. Green, Olathe:—"An ounce of prevention is worth a pound of cure"—is better than cure, especially in preventing puerperal sepsis. Physicians should qualify themselves to make an external examination, and not vaginal. They can very soon possess themselves of the information without a vaginal examination. All physicians should feel relieved if the birth has come about without a vaginal examination. I know that I always feel relieved, for the danger of sepsis is lessened. That women do infect themselves is true particularly when the physician has left too soon. I had a case a few days ago. I was informed that everything was all right, but I found on the next visit a fever of $102\frac{1}{2}$; and, when I made examination of the vulva, I discovered that there was enough infection to cause puerperal fever: but, by the use of antiseptics, the fever subsided and always will. If she had been thoroughly cleaned up in the first place, she would have had no trouble. It is a fact that the lying-in hospital is the safest place for the lying-in woman. I think it is the case that in all probability puerperal fever is as frequent in general practice as it was forty years ago.

Dr. Stemen:—I am not an obstetrician. I want to say just one thing, that is, that the normal secretion are the best antiseptic that we can introduce. I believe that puerperal fever is largely caused by douches, etc. If you will see that your hands are clean and let nature do the rest, you will have no trouble. I think if we had to do all the things that have been advocated today, there would never be any baby born! We were told forty years ago that if we attended a case of erysipelas, we could not attend a case of confinement for three weeks. We were also told to use the tincture of iodine for an antiseptic. It is a good thing today. Let us let the normal secretions alone; not introduce antiseptics into the vagina; and, not make very many examinations, and I think we will get along all right.

Dr. Johnson:—I have had recent training in new schools and cannot make an examination without making a vaginal examination. If the gentleman over there who advocates non-vaginal examination would give us a lecture on the subject, we should be grateful.

Dr. Green, Olathe:—If the gentleman will investigate the latest authorities, he will find it is the case. Read up!

Dr. Kenney:—One of the best ways to prevent puerperal sepsis is by looking after the secretions. I think the normal secretions will do just as much as anything else. How are we going to do this? A great many physicians still keep up the old idea of laying a patient right on her back, tying on a band, and stopping the secretions that way. Keep the secretions flowing. If necessary, raise the head of the bed; and, if you keep the flow going, there will be considerable difference in this fever.

Dr. Liggett, Oswego:—I want to speak of the matter of the difficulty of diagnosing. I heard Dr. Pollock of the Polyclinic in Chicago say: "In making a diagnosis always use the fingers in the vagina, sometimes it is necessary to use the half hand." Dr. Pollock is pretty good authority, it seems to me.

Dr. Green.—It is claimed by the best authorities, to disinfect the hand.

Dr. Walker, Salina:—I wish to say a few words along a different line entirely from any that has been spoken on so far. It seems to me that we could put obstetrics on a higher plane and educate not only the laity but the doctors as well that obstetrical work means surgical work. The surgeon will not cleanse his hands for less than \$25.00. The obstetrician will go out into the country for a day for \$8.00 or \$10.00. It is not worth while to clean one's hands for that. If we could put obstetrics on a little higher plane, then the profession would be benefitted and the laity would understand the situation better. I do not believe that obstetrics as it is practiced today is half way paid and I am trying to drill this into the minds of the doctors and the people of my community. It is an outrageous thing just to put a level price on every case. I believe that along with that reform would come fewer cases of sepsis.

Dr. Masterson, Kansas City:—I believe a physician should just as conscientiously cleanse his hands and treat his patient if he got only \$5.00 as if he got \$50.00.

Dr. Mitchell:—I heard an eminent orator speak once on this subject to a class of students. He said: "Young man, when you are called to attend a woman in confinement see that everything is ready: work yourself up into a state of monstrous inactivity; sit down, and do nothing." I believe that is the proper thing to do. Too much interference is the cause of more trouble than all things else. I believe that the Maker of the woman and the Author of all these things made them right. I believe we interfere too much. I have not had as much experience as many; but in over 400 cases I have not had a single case of puerperal sepsis. I think as Dr. Stemen has already said, that the natural secretions were made to take care of most of the trouble and would do it, if we will only let Nature alone. There is one thing to be considered: We have nearly doubled the number of people in the country that there were forty years ago; therefore, we have raised the percentage.

A motion was carried to close the discussion by the remarks of the reader of the paper.

Dr. Parrington:—I only regret that Dr. Biddle is not here this afternoon to defend his paper, if defense be needed. I do not think it is. I thank you for the enthusiasm with which it has been received. Down in our country, we have a little pamphlet such as you have heard of this afternoon. A committee has been formed to formulate laws to be followed by those who expect to become mothers soon. A report was made, but the report was considered too lengthy to offer. In due course of time, that report will come. It makes no difference what antiseptic is used: they can use what they please, but the society will advocate their use, mentioning the things that will be all right. I want to thank you for the very kindly discussion that you have given this paper of Dr. Biddle's.

Report 7:—Dr. Uhls having resumed the chair Dr. J. E. Oldham of Wichita read a paper on METRITIS, which was very lengthily discussed, Dr. Lyman of Manhattan, moving that the discussion be closed. The motion carried and Dr. Oldham closed the discussion.

METRITIS: ETIOLOGY, CLASSIFICATION, CLINICAL COURSE, PATHOLOGY AND TREATMENT.

J. E. Oldham, M. D., Wichita, Kansas.

No subject within the jurisdiction of the gynecologist is of such vast importance as metritis.

There is no time in life from the period of adolescence until the menopause is well past, that women are exempt from it, and even when the last named mile post in the life time of woman is past she frequently has the sequella of chronic metritis to add to the aches, miseries and distresses of normal old age. What is true in regard to age may well be said to be true in regard to class, although it is a comforting reflection that the laboring and working women suffer less with metritis than the wealthy, idle, pleasure seeking and amusement loving class. There are many reasons why this is true.

First, the laboring class is uniformly stronger and more rugged. Their life is simpler, their emotional natures are not so constantly under the severe strain of excitement on the one hand, and depression on the other; they, as a rule, make fewer attempts to interfere with the progress of gestation, and do not resort to the various harmful methods to prevent conception. I shall later on call attention to abortions and the prevention of pregnancy as among the most prolific causes of metritis.

In studying metritis clinically one is impressed with the need for classification, yet the tendency when the disease becomes chronic is to the same condition and is characterized by the same symptoms.

First we find the division into acute and chronic metritis. Locally it is described as cervical, corporeal and general.

In causation puerperal, post-puerperal, gonorrheal and traumatic. Pathologically, it is styled granular, fungus, ulcerating, etc.

A classification given by Pozzi is as comprehensive and easily understood clinically as any, viz: "Acute inflammatory, hemorrhagic, catarrhal, chronic, painful." The last is the one which we as gynecologists are more frequently called upon to treat.

I do not consider endometritis as a condition entitled to consideration; for as has been observed by some of the best authorities I cannot understand how an inflammatory condition involving only the single layer of endothelial cells which constitute the endometrium, could produce symptoms which would be recognizable.

Inflammation is a condition which begins and ends in the connective tissue.

In various conditions when the initial lesion is on the mucous membrane no specially serious symptoms are observable until the trouble has extended deeper and involves the submucous connective tissue, which involvement is announced by the onset of serious symptoms both local and general.

Acute metritis is ushered in by chill and fever, and these phenomena sometimes mark the exacerbations in chronic metritis. There is pain and abdominal soreness and the patients move about in a stooping, hesitating manner that is quite characteristic of the trouble. On examination by touch the uterus is found enlarged and tender, and usually displaced downward or retroverted. On inspection it is observed to be red and swollen and a bloody discharge from the os is frequently seen. The classifications, granular, fungus and ulcerative, are but different stages and conditions of the inflammatory process.

As before stated it is the chronic form of the disease that we are most frequently called upon to treat and this condition has a wide range in etiology, in pathology, in symptomatology, and a most unsatisfactory course of treatment. For in many instances relief from the distressing suffering of the patient means the ablation of the organ and this demonstrates the paucity rather than the triumph of our art.

As causative influences in the young and unmarried, any condition which disturbs or interferes with normal menstruation such as over work, over excitement, severe emotional disturbances, excessive mental strain as observed in high school girls and teachers, loss of sleep and the excitement incident to a social life as often seen in young girls that frequent balls and parties; taking cold at and near the menstrual period. The acute exanthemata, measles, scarlet fever and small pox.

In the newly married excessive sexual indulgence and over activity at a time when quietude and rest should be observed. Attempts to frustrate and prevent conception by cold ablutions by the injections of irritants and even corrosives, as well as intrauterine instrumentation.

Gonorrhea is a potent factor in the production of metritis. Not only in the acute form of the disease but in the old chronic condition in the wholly unsuspecting married man, who, as a reminder of his licentiousness and rapid youthful career, has his stricture with its recurring exacerbations and gleet discharge. The discharge from

a stricture is unquestionably a factor in the production of chronic metritis. This discharge may lay dormant in the cervix for an indefinite time and following abortion or labor gain access to the uterine cavity.

By far the most frequent cause is parturition. Normal labor, spontaneous and induced abortion all leave the uterus in a condition of congestion and hyperplasia and in the most favorable state to receive infectious germs. Particularly in abnormal labors, where pieces of the placenta have remained in the uterine cavity is infection liable to occur.

Emmett pointed out the relationship between lacerations and metritis many years ago and while his conclusions led to much controversy, I believe that today the profession all over the world accepts them as true.

In regard to displacements it is frequently difficult to decide which is cause and which is effect. In certain cases the displacement seems to be congenital. In examinations of many young subjects with versions and flexions I have almost unvaryingly found a metritis, and I believe that with exception of congenital displacements, that metritis is the cause of these conditions.

In studying the course of pelvic diseases in women one is impressed with the similarity of subjective symptoms. The symptom complex differs but little whether the disease is metritis, salpingitis, fibromyoma, or even cancer, hence it takes a careful local examination to determine. It cannot be amiss to review some of the important general symptoms of chronic metritis. The uterus is richly supplied by the sympathetic nerve system through the hypergastric plexus and from the cord by the internal pudic. Neuralgia is therefore very frequent, and this is not limited to any special region.

Simpson and others called attention to that dreaded condition coccygodynia and established the connection with metritis. The functual neuroses cover the whole field of hysteria. There is a peculiar weakness or asthenia marked by a profound depression and these patients are wholly incapable of any muscular effort. Even the gravest nervous troubles, such as chorea and epilepsy owe their presence to metritis. The pain and neuralgia prevents exercises, the reflex impairs digestion. Alimentation and nutrition are disturbed and the vicious circle is complete.

Palpitation from the same cause is frequent. Cough of a peculiar dry and hacking character, which, until disease of the lungs is eliminated by careful examination, the patient may be suspected

of tuberculosis. I think that in every case of chronic disease in women, it should be the practice to carefully examine the uterus.

Physical signs: By touch the cervix is found to be enlarged and hardened, with or without lacerations, except in the rare cases where the disease is confined to the body of the organ, and in these cases the cervix is usually smaller, elongated and pointed. In many instances the cervix is found to be ulcerated and eroded.

Again there are hard bodies felt beneath the mucus membranes small glands which have undergone cystic degeneration. By pressing upon the cervix or at the bottom of a laceration a severe characteristic pain is produced, and bi-manually the body of the uterus is found to be exquisitely tender.

By touch also we note the presence of adhesions or the mobility of the uterus. By measurement with the uterine sound the depth of the cavity will be found to be abnormal. I doubt the advisability of sounding the uterus, especially in an office examination. This should never be done except when the vagina has been carefully cleansed and sterilized on account of the danger of carrying infective germs into the uterine cavity. The exploration of the cavity will of course mark the presence of and reveal the character of the discharge. The discharge from the cervix is thick, tenacious and viscid; that from the cavity of the uterus is thin and lymphid, either colorless or tinged with blood.

The various forms of metritis are well indicated by the condition. The acute by the chill, fever and pain with the tenderness found by examination. The catarrhal by the erosion of the cervix and the leucorrhoeal discharge. The hemorrhagic by the excessive menstruation and the irregular flow. This form is met with in young girls and in women near the menopause; also after abortions. But as I have before stated, that it is the chronic painful form that we are more frequently called upon to treat and the symptoms, I have indicated.

The pathological changes are those incident to a great increase of connective tissue. In the early stage a general engorgement of the blood vessels, and a softening and enlargement of the organ is noted; following this the new growth of connective tissue. The blood vessels are pressed upon and the blood supply is reduced. Atrophy of the muscular tissue, which tissue is replaced by the connective. The organ takes on a densely hard, and almost woody consistence. These changes are not rapid but extend over a period of years. The glands and follicles at first are over active, stimulated by the excessive blood supply and fungus and polypoid growths on

the mucus membrane are frequent. Later these organs undergo a cystic degeneration.

Salpingitis in consequence of the continuity and identity of the tubes and uterus is an almost ever present complication. Clinically we note cystitis and proctitis as complications.

The question, does metritis predispose to cancer and to fibroid growths, has always been a mooted and unsettled one, and probably will continue so for many years, and the question is too large to discuss in a paper. We can enumerate the classic symptoms of metritis. We can tell of the undermined general health, of the persistent cough, the loss of breath, the progressively increasing emaciation, the abdominal and pelvic pain, the precordial anxiety and palpitation, but when we consider treatment we strike the Gibraltar upon which many beautiful theories have been wrecked, and almost leave us at the mercy of the most conflicting and radically different opinions.

On the one side are arrayed the phalanx of adherents to an alterative medicinal treatment including almost every form of eschrotic, chloride of zinc, pesulphite of iron and a host of other similar ones; also the mild alteratives such as solution of nitrate of silver, tr. iodine and even the mild aqueous solutions of iodine applied to the lining membrane of the uterus. This course of treatment supplemented by depleting vaginal tampons of boroglyceride or ichthyol in various combinations. The object of which is to deplete the uterus and adnexa and relieve pain.

Internally a general tonic and supporting treatment with special attention to neurotic conditions and the functional disturbances incident to this is always indicated.

On the other side are arrayed the surgical gynecologists who insist that the condition is surgical and only amendable to surgical treatment. Scarification of the cervix; incision of the cervix: Emmett's operation; Schroeder's operation; curettement, with or without either of the above mentioned.

A somewhat careful study and observing the results in my own, as well as the results attained by other practitioners, has led me to at least positive conclusions. In the acute form of the trouble the tendency here, as in almost every other acute inflammation, is to recovery. There are very few cases of chronic metritis that owe their presence to a preceding acute inflammation. The same laws or rules of treatment which obtains in other acute inflammations are applicable in acute metritis. The first essential is absolute rest to the part. Mild catharsis, careful dilatation of the cervix and

carefully and gently cleaning out the uterine cavity with a gauze covered or very dull curette, and gauze drainage, with me constitutes the treatment. The sharp curette has no place in the treatment of acute metritis.

In the chronic form, or rather forms, of the disease, we are confronted by an entirely different proposition. The disease is rebellious in the extreme. There is a complete change in the anatomy of the organ. In health the bulk of it is muscular tissue with a labyrinth of anastomosing blood vessels. In a well advanced state of the disease the blood vessels are obliterated and the muscles are atrophied. These changes once wrought and any thing approaching a normal condition will never be attained.

I have never known a case of chronic metritis to be cured. I have tried all the various plans that I have enumerated and the results were unsatisfactory in the extreme.

To me the laws of general surgery offers the only rational treatment. These are, first; the life of the patient; second, the function of the part; third, the form of the part. But this is modified by the age of the patient.

Given a case of chronic metritis in young middle life, age 25 to 35, with impaired general health. Ablation of the uterus and adnexa is the only treatment that promises a restoration of the general health. Where the patient is near the menopause, I believe the more conservative operations justifiable. Emmett's or Schroeder's operation on the cervix, with a careful cleansing of the uterine cavity will in many cases at least prove palliative and hasten the menopause.

In chronic metritis, pregnancy is rare and abortions frequent; and the old theory that pregnancy would cure metritis has been abandoned. The tendency in these cases when pregnancy has continued to full term is to return to the same condition or to an exaggerated one of that which precedes the pregnancy. If a flexion or a version was present before the pregnancy it will be there at the end of gestation, and the enlarged and hardened uterus will not be improved. With the axioms of life, function and form to guide us, I believe hysterectomy is not only justifiable, but conservative treatment, in chronic metritis.

While I would advise ablation of the uterus, with tubes and ovaries, in cases where the general health is undermined, I would not recommend so radical treatment, except in such cases, but would perform one of the conservative operations on the cervix, with or without ventro fixation according to indications and need for this to correct a version or flexion, cleanse the uterine cavity and apply

iodine to the lining membrane.

Rupture of the perineum or a relaxed vaginal wall always calls for repair for the one and narrowing the other; thereby giving support to the pelvic viscera and assists in completely emptying both bladder and rectum.

The Barnes, Dec. 21, 1906.

J. E. OLDHAM.

DISCUSSIONS.

Dr. Gray:—Mr. Chairman and ladies and gentlemen of the Kansas Medical Society: I think the doctor's paper is rather too good a one to allow to go undiscussed, although he has certainly covered the ground pretty thoroughly. There is one point in connection with the paper on which I wish to speak: that is, that in the chronic form of metritis, complete hysterectomy offers the only cure. It seems to me that this would be a rather radical operation to apply in all cases. Perhaps, at certain ages it might be advisable, that is, in women who have about completed the menopause; and, in cases where there might be some suspicion of beginning malignancy, even if not positively demonstrated. As the doctor has stated, in most of these cases we have, if not existing laceration, more or less scar tissue as the result. In certain cases, they have followed repair of laceration that has previously existed. It seems to me that in many of these cases, we get better results not by repairing existing lacerations, but by a high amputation of the cervix. Of course, this alone would not be sufficient cure for metritis; but, I believe that in many cases the condition is very much improved over what it would have been by merely repairing the lacerations. Most of these cases that come under my notice, one might say almost without exception, there is a condition existing outside of the uterus that would have to be corrected before much benefit could be expected. They refer more to misplacements of the ovaries and the uterus. For my part, it seems to me that hysterectomy would have to be confined to only a few select cases.

Dr. Bolton.—With all due respect to Dr. Oldham, I shall have to take exception to him in his position. It all simmers down again to surgery. I believe that a large majority of these cases can be relieved and many of them cured by the general practitioner. It is a sad commentary on the medical profession if we have to concede to Dr. Oldham his position; and, I do not believe that we do.

Dr. Stemen:—I have been very much interested in the paper which the doctor has just read. He has certainly given great thought and investigation to his subject. The only point to which I wish to refer is that referred to by my friend who has just spoken. I could not consent to the statement made by the doctor that in chronic metritis the best thing is abolition of the uterus. For many years I have practiced surgery—general surgery—and I have limited this operation to malignant diseases. I feel that the doctor is getting on very dangerous ground in advocating for chronic metritis, the removal of the uterus. I was very much pleased with all that he said until he came to that point. As an old practitioner, I must raise my voice against that for the reason that I believe that chronic metritis can be cured. Many years ago, I was with a fine gynecologist in Cincinnati in his hospital. I know that we cured cases of chronic metritis in that time, even with the

old tincture of iodine and good general treatment, etc. Quite a number of cases have been cured without the knife. The great trouble with the profession today is charging us surgeons with a too ready use of the knife. Many a practitioner says: "O, if you call such and such a man, he will say 'operate.' " They say sometimes that we will operate on anything that we can get to lie still long enough. However, if it is the best remedy to take out the uterus and make a complete hysterectomy we ought to do it, regardless of what people say. The duty of the physician is to do the best thing; and if that is the best thing, we ought to do it. Harvey said once that the statement of no one over thirty years of age should be believed. I may be too old to talk. However, I must raise my voice against the doctor's statement.

Dr. Munn:—After the remarks of my friend Gray, I am surprised that any of you gentlemen who have gone through the long experience in the use of the tincture of iodine and other such remedies, would take the position that our old friend does here. No case of chronic metritis is ever cured by replacement of the organs; by repair of the lacerations, etc. I have done it, and done it, and done it. It might be helped for a little while, but as to cure, it is impossible. I wish to go on record as saying that the cure for chronic metritis is the removal of the organ.

Dr. Murdock:—Twenty-one years ago in the medical society of Kansas, I exhibited an uterus that I removed for malignancy. I think it was the first operation for vaginal hysterectomy in Kansas. I was met with the statement that removal of the uterus was non-surgical; that it was something that was a dangerous doctrine to advocate. Get all the doctors at it and they would remove the uterus for any and every case. Now, today I feel like taking the stand that removal of the uterus for chronic metritis is non-surgical and unwise, until a very thoro course has been adopted in trying to cure it. We have a granular metritis—now, we would not remove the eye if the mucous membrane were granulated. It seems to me that there is a middle ground that we should take. We should first try and see if we could not remove this condition before we would advocate such an heroic measure. It does not matter what becomes of the common practitioner—whether he gets a chance at it or not—I would not take that into consideration; but, whether it would be necessary or not. If we thought from our experience that it was not necessary, we should get together on common ground and counsel and refer our patients to different doctors who have skill in these things. We should consult their judgment. As for the high amputation of the cervix—I am more in favor of complete hysterectomy than I am of a high operation. I have done a good many vaginal hysterectomies—it is a very safe operation, not looked upon as dangerous; and, I should think it much better to remove the uterus entire than to have a high operation. It is so much quicker. I feel disposed to offer a protest against removal of the uterus for granulation or something of that kind until we have made every possible effort to treat them without.

Dr. Harper:—I believe more could be done by treatment than is done. However, I had an experience which I wish to mention in connection with the use of drugs for the relief or cure of metritis. Boro-glycerid, as you all know, is largely used by the general practitioner for metritis. I had occasion to call on a surgeon for a little advice in a case about which I seemed doubtful. We discussed the use of boro-glycerid. He drew a bottle from a

lower shelf, a six ounce bottle of boro-glycerid, half full. He said: "Here is what I think of the treatment of women having metritis by the use of boro-glycerid. I have had that bottle three years.; and, it will perhaps last me another three years."

Dr. Sudler:—I have listened to this paper with a great deal of interest, but it seems that there should be some way to help even these extreme cases without resorting to such radical measures, though I realize the truth of what the doctor has said. The development of the opsonic method in the treatment of similar morbid conditions in other parts of the body seems to give us hope that it may be efficient here also. In a recent number of the "Lancet" Dr. Kenneth W. Goadley describes his method used in the successful treatment of some intractable cases of pyorrhea alveolaris. Pure cultures of the particular organism causing the trouble were obtained. Then, these were killed after Wright's method and used as vaccines, so as to build up the resistance (opsonic index) of that particular individual to the specific organism causing the trouble. It seems to me the same method could be applied to the stubborn cases of metritis with hopes of equal success, and that perhaps with a better development of the "laboratory method of treatment" many of these localized chronic inflammatory processes could be cured without appealing to such heroic surgical measures for relief.

Dr. Hamilton:—I want to put myself on record that I do not believe with the doctor in operating on chronic metritis. We know the pathology of inflammation; we know the cause of it; and, we know well that there must be a cause for inflammation; hence, we do not operate for all inflammations. It would be absurd that you would cut out an inflammatory body because it was inflamed. I believe that we have a number of medicines in our pharmacopeia that will relieve, after the cause has been removed. I have had good success in a treatment that has not been expensive. It is glycerin and ichthyol half and half. I am absolutely opposed to hysterectomy for chronic metritis unless it is as a last resort when nothing else will do; then and not until then.

Dr. Blasdel:—One question is the question of diagnosis. All metritis is not chronic metritis. When we have a muscular tissue or vascular tissue destroyed, then hysterectomy is all right. It is the only cure. We could just as well say that a kidney that was destroyed by disease could be restored by medicines as to say that this tissue could be "cured" that is already destroyed.

Dr. Reynolds:—I recognize the danger of becoming one-sided when we get old, as Dr. Oldham, Dr. Munn, and our honored president. Therefore, on this account I take a middle ground. We should be very slow to reach the conclusion that the abolition of the uterus is necessary. It has to be done once in a while, but I think the cases are exceptional.

Dr. Johnson:—There is one thing that has not been mentioned that may be used with a great deal of benefit in these cases very often—that is, a cautery. It has to be applied very lightly and carefully, and a great many of these cases could be improved. This is a danger, it seems to me that might be met in the method of which Dr. Sudler speaks. The use of serum would need a great care in its administration. We know that there is nothing any more poisonous than the serums when they are applied.

Dr. Barnett:—If I understood the paper, Dr. Oldham said pregnancy would rather increase than cure metritis. With this I agree, if after the

labor is over, a metritis or a chronic metritis is left untreated. But, I want to rise to state that if there is a time when chronic metritis can be properly treated, it is immediately after labor when the uterus and adna are making an effort to undergo a change to a normal condition. Where I know that a chronic metritis has existed, I carefully try to carry my case through the labor; and, would not hesitate in a case of that kind, just as soon as the discharges have disappeared, to assist the uterus to attain a proper normal condition, by proper applications. The only way where I have had great success has been where I made a particular effort immediately after labor.

Upon motion the discussion was closed.

Dr. Oldham:—First, I want to thank you for your very liberal discussion of this paper. But, I believe that you lose sight of just the language that I used. I said that when the general health was undermined that then the only thing I knew that had been in any way successful with me was hysterectomy. I assume all that you have spoken of. All that has been carried out, and gone over and been unsuccessful. The resulting condition: the wasting away of the normal structure, the destruction of the blood supply, and interference with the nutrition of the body. That is the condition where I advocate hysterectomy. That is the condition of these cases when they come to me. All these things mentioned have usually been done. I have tried all these treatments. After a case has reached the woody condition, I find that all the cases come back in a little while. They are benefited for a time; you relieve the symptoms. A few years ago, John B. Dever said: "If you would prevent cancer, do a hysterectomy in a case of chronic metritis." I do not know this, but I do know that it is only a step from inflammation or a form of inflammation to some malignant condition.

—O—

Operation for Glaucomia.

Dr. Vollert, of Leipsig (Muench. med. Woch., 1906, No. 50) encourages the incarceration of the iris in the wound in iridectomy for glaucoma, as we thus secure a permanent preservation of the normal tension.

Ulcus Serpens.

H. W. Woodruf (Journ. of Ophthal. and Oto-Laryng., April) emphasizes the need of absolute rest in darkness in the treatment of ulcus serpens, and in cases of hypopion injection of cyanide of mercury. He says that he has never seen a case where Saemish's section was necessary.

AUTOMOBILES IN COUNTRY PRACTICE.

By L. Reynolds, Horton, Kan,

The time has not yet come, when from the standpoint of economy, every physician can adopt the automobile in his practice. I predict that within the next five years, prices will more nearly approach the cost of production. In my opinion a machine can and will be built for five or six hundred dollars with ample power, strength and reliability for a physician's use. It can scarcely be said that such a machine is on the market.

When this time comes this fascinating method of transportation may be considered as a competitor of the horse with due reference to economy. When contemplating the purchase of an auto, I subscribed for a journal several months in advance and read carefully all the information it contained. I also interviewed frequently owners of machines. This theoretical information was of considerable practical value when I came to use a machine. The anatomy and physiology of the thing is very important if one expects to acquire efficiency in their management.

I would not advise any one to purchase an auto who does not endeavor to take the main care of it himself and learn all the adjustments.

Other questions to be settled are:

Shall the machine be an air or water cooler?

Shall it be a steam, gasoline or electric?

Shall it be single or multiple cylinder?

Shall it be a chain or shaft drive?

Shall it be solid or pneumatic tire?

First. The air cooler machine requires a good deal more oil than the water cooler, which it burns, causing the carbon deposits in cylinders which in time require cleaning out or they lose power. This I learned from an owner. The main drawback of the water cooler engine is that in cold weather freezing may occur, breaking cylinders or radiator. This can be avoided in two ways, one to use a solution that will not freeze and the other to draw off the water at the end of each trip, putting in a quart or more of wood alcohol to keep from freezing any small amount of water that might not be entirely drained off. As three or four gallons is the usual amount of water required, it runs off in about ten minutes and requires but little time to replace. Have tried the above and where trips are not too frequent, prefer the latter method. My judgment is that the aver-

age user will be better satisfied with the water cooled engine.

Second. Those I have known to try steam, have abandoned them; the electric seems to lack power for hills in country roads, besides outside of cities they cannot be properly charged. They have the advantage of very quiet running.

Third. The single cylinder seems to be going out of use as multiple cylinders give more regular impulses, causing less jerking and vibration. Four cylinder cars apparently promise to give most general satisfaction.

Fourth. Chain driven machines seem a little less expensive to produce but make more noise; the chains collect dirt and wear out links, losing power or occasionally jumping off the sprocket wheels. Experience seems to be popularizing the shaft drive.

Fifth. The liability to the puncture of the pneumatic tire has lead some to try the solid tire, but the greater jar to machine and occupants has been a greater objection than the occasional puncture. One can carry an extra inner tube which can be made to quickly replace the punctured one and cause but little delay. I have had but one puncture in a year, so I do not regard a puncture as a serious or troublesome accident. The larger the tire the less liable to puncture, owing to greater thickness. Think my three and one half inch tires will easily last me two years without retreading.

If you expect to purchase and use an auto without grief, you will be disappointed. I have a friend who has had nine machines extending over as many years. He says the fellow who says he never has any trouble is mistaken—no matter what make he uses. Everyone takes some chances in learning to use them.

The only way one can do any harm with a gasoline auto is to run into something, as they never explode. There are plenty of chances, however, of running into ditches, buildings, stone walls, etc. There are several things to think of at the same time and until one has formed the habit of running he may omit some important manipulation at a critical moment.

A little sand, dust, rough or muddy roads cause rear wheels to skid, especially if running fast, thus throwing the machine quickly and squarely across the road. A beginner should always run slowly until all liabilities are discovered and understood.

An objection of some seriousness is the danger of frightening horses. Lack of reasonable care on the part of some drivers of automobiles has created a good deal of prejudice against them in rural districts. Unless users use due caution this influence is liable to react on them and result in unreasonable legal restrictions. Com-

mon decency and regard for the welfare of others ought to influence us to cautiously avoid scaring either teams or drivers, for the latter are more often scared than the teams.

The Kansas state law regulating automobile speed is a reasonable one and if we avoid unreasonable local restrictions by town councils we have nothing objectionable in this direction.

The very general use of automobiles has now accustomed many horses to them and people are more careful about taking wild horses on the roads. In our own neighborhood we soon learn to know the safe and unsafe horses, so we may act accordingly. In one year's running I have never caused a runaway or injury. The only trouble I have had was in passing wild horses that were standing hitched and no one near to take care of them. Two different horses have broken loose without doing any harm and a third was a wild colt which had been carelessly hitched, kicked itself loose from a sulky.

An arrogant independence has been very noticeable on the part of the makers and dealers. In consultation with other owners I find makers very generally fail to make their promises good. This has been my experience. The demand has been so great and the prices high, that makers have not been as careful in construction and material as they should.

In the satisfaction one gets when his machine works well, he is apt to forget any annoyances he has had and is liable to give any prospective purchaser a too sanguine idea of their ready utility. Any one of five points when out of adjustment may balk the whole machine. These points are the spark plugs, induction coil, battery, commutator (the timer) and carbureter (the mixer). It may seem very mysterious sometimes what is wrong, but time and experience usually enables us to make a diagnosis. When this is done the treatment is generally easy.

The new user gets a good drill in self control as he is apt, when his machine balks, to have such volunteer remarks as, "Hello Doc, broke down," "Try twisting her tail," and others of similar import.

I would not recommend an auto to a young single doctor to promote his interests with his best girl, as his attention is apt to be too much divided to do justice to either.

Never run fast in narrow places or near ditches. Wide level fields are good places in which to take first lessons. After reasonable efficiency in their management is attained, one should be able to average fifteen miles per hour, safely and easily, on good roads. Twenty miles per hour is easily made on good, level roads. An intimate knowledge of electricity will be of great utility here, more

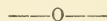
than any where else in the private practice of medicine. Some things: lubrication, steering and control must be learned mostly by experience. Many makers give very inadequate instructions to purchasers. One should learn before purchasing, something of the significance of cylinder, diameter and stroke, compression and cycle. Power and weight should receive careful consideration, the former is usually greatly over estimated and the latter is much understated. For instance, my machine was listed at 1500 pounds, and weighs about a ton, while its power is placed at 18 horse power, when I think it is more nearly 10.

A good machine may be used eight or nine months during an average year in the country and nearly the whole year in paved cities. Think the expense, aside from depreciation in value, need not exceed fifteen dollars per month for all supplies and repairs after one has learned all ordinary adjustments and can take care of the machine himself. I consider a half hour of work daily, during their use, necessary to keep them in good running order. To me this is mostly diversion and amusement.

One who has no mechanical ability and cannot acquire any, may not find an auto a good or satisfactory investment. I use dry cells for battery and carry an ameter (dry cell tester) with me so I may anticipate exhaustion of cells in time to renew and avoid being stranded away from home.

They may be used in considerable mud but not many volunteer to take them out in mud, except to run home when caught out in the rain. Progress is rather slow and hard on the machine, besides it is considerable work to clean off the mud.

I always feel lonesome without my machine and would not do without one at much greater cost.



Electricity in Eye Diseases.

W. F. Coleman, (J. A. M. A., April 27th) endorses the use of electricity in eye diseases, and, in spite of authorities to the contrary, reports excellent results in a number of cases, including vitreous opacities, amblyopia, intraocular haemorrhage, xanthoma, paresis of accommodation and ocular muscles, pterygium, etc., where other means have failed.

THE JOURNAL OF THE KANSAS MEDICAL SOCIETY.

Entered at the Postoffice at Columbus Kansas, as Second Class Matter.

CHAS. S. HUFFMAN, EDITOR
J. E. SAWTELL, }
GEO. H. HOXIE, } ASSOCIATE EDITORS

Subscription rates: \$2.00 per year; 20c single copy. Advertising rates furnished promptly on application.

Dr. Oldham's paper on Metritis was read at the Kansas City meeting in May. The printer omitted publishing this at foot of his article.

A communication was received from Dr. L. A. Van Pelt of Paola, who is coroner of Miami county, asking why the coroners of the different counties in this state could not furnish the Medical Department of the University with dissecting material. It is often the case they have unclaimed bodies which could be sent direct to the university for anatomical purposes. This seems to be a good suggestion, and if the University would keep in touch with the coroners much needed material could be secured in this way.

Many of the county societies have adopted the plan of preparing a program for each month for the entire year. This plan has many advantages over the old way of preparing the program after each meeting for the ensuing meeting. By preparing and publishing the program for the entire year, all can familiarize themselves with the different subjects, and can discuss them more intelligently. And those who write papers are given more time to prepare them, and as a result, we have a better class of papers. In this issue we publish the program of the Shawnee county medical society and it is well arranged, and a most excellent program.

The Interstate Medical Journal, St. Louis, announces the purchase of the St. Louis Courier of Medicine, one of the oldest medical journals in the West, and its consolidation with the Interstate on July 1st.

The St. Louis Courier of Medicine was established in 1879 by an association of prominent St. Louis physicians. It has always com-

manded a large following throughout the West and South, and held the respect and esteem of the entire profession of this country.

This merger removes from the field an old and highly esteemed contemporary, and its consolidation with the Interstate adds strength and prestige to that periodical. This is the fourth medical journal that has been purchased and absorbed by the Interstate during the past few years.

The Pathology and Treatment of Hay Fever.

One of the most striking pathological features of this malady is a turgescence of the turbinal tissues due to extensive dilation of the capillaries. That this is the result of an angioneurosis, involving a more or less pronounced local vaso-motor paralysis, is pretty generally conceded.

In treatment of hay fever with Adrenalin Chloride it has been suggested that weak solutions, frequently applied, are apt to yield better results than the occasional application of strong solution. The application of the solution of Adrenalin Chloride stimulates the vaso-motor supply, resulting in a contraction of the capillaries. Over stimulation, by reaction, is very sure to result in a complete paralysis of the vaso-motor supply in the region affected. On the other hand, gentle stimulation with weak solutions is not so likely to be followed by a reaction.

Solution Adrenalin Chloride(1:1000) may be diluted with normal salt solution and sprayed into the nares and pharynx.

Adrenalin Inhalant may be preferred to the aqueous solution, for obvious reasons. This product contains one part of Adrenalin Chloride in one thousand parts of an aromatized neutral oil base, with 3 per cent. chloretone. It is vaporized by means of a nebulizer.

Adrenalin Ointment may be applied to the turgescient nasal mucosa by means of a cotton applicator. Henry Guy Carleton (Therapeutic Gazette, June, 1907) says that "Relief can be accomplished more quickly by smearing one or two minims of ointment containing 1:1000 of Adrenalin between the brows and half way down the side of the nose than by the injunction and spraying of the nasal mucosa." The modus operandi is explained as follows:

"The effect is to allay the irritation of the supraorbital, supratrochlear, and infratrochlear and frontal nerves, and the superior and inferior nasal, the nasal rami of the superior maxillary, and the nasopalatine nerves, all of which are involved in a severe attack. Those rami in the posterior nares which may be affected will be relieved simultaneously, exactly as all branches of the supraorbital

affected in a supraorbital neuralgia are relieved when an application of Adrenalin ointment is applied only to the supraorbital foramen."

Messrs. Parke, Davis & Co. issue a brochure on the treatment of hay fever, which will be sent gratis to any medical man upon request. We suggest to our readers that they send for the brochure, as hay fever is an exceedingly interesting and timely subject.

Our State University Still the Medical School of the Southwest.

The following clipping from the Kansas City Times for May 1, 1907, gives the conclusion of the discussion raised by certain medical politicians of Kansas City whereby they hoped to weaken the influence of Kansas University. Kansas City will not lose anything by the decision because Kansas is just as able as Missouri to build a "Harvard" or a "Johns Hopkins." In fact one great school in Kansas City will be better than two mediocre ones,—because a population of 350,000 people is not sufficient to maintain two university schools plus the attendant and inevitable camp followers:

"The executive board of the Missouri state university decided last night to abandon the project of establishing a school of medicine in Kansas City. The subject has been under consideration since Monday between the board and Mayor Beardsley and the members of the committee of the city council. In declining the proposition the executive board of the university regards the matter as closed.

"We simply could not agree to the conditions named by Mayor Beardsley for the establishment of the medical college," said Walter Williams, chairman of the executive board, last night. "The mayor would not guarantee to the university any clinical facilities. This question he decided would be left in the hands of the board governing the general hospital, we believe. The members of the executive board and the curators of the university have given up all hope of establishing a medical school here. The members of the executive board will return to their homes tomorrow."

STATEMENT FROM THE M. S. U. BOARD.

As chairman of the executive board, Walter Williams issued a statement setting forth the position of the university regarding the medical school. This statement follows:

"The medical college of the Missouri state university will not be located in Kansas City, nor will the Missouri state university establish a graduate school in Kansas City.

Mayor Beardsley and his committee have submitted to the uni-

versity curators a proposition which makes possible such an establishment, and this proposition has been declined. Under the proposition of the mayor there is no guarantee of clinical facilities to any medical institution save as these facilities are granted by the favor of a hospital board. To secure the control of the appointment of this board and the direction of its policies might continually drag into local politics any institution desiring to have maintained sufficient clinical facilities. The Missouri university cannot, of course, enter such a contest, however willing it might be to relieve Kansas City of the large expense of the municipal hospital's medical administration. Moreover, it cannot afford to enter upon the establishment of a great medical college when the essential foundation of hospital clinics for research and instruction is left thus uncertain.

The Missouri university has not sought to shut out of Kansas City other educational institutions or to deny the guarantee of clinics necessary to any real medical college. It has no quarrel with any. To build up a medical school which would make Kansas City the center of medical education of the Mississippi valley, adequate though not necessarily exclusive hospital clinical facilities must be permanently secured to any institution seeking such establishment. This is impossible under the mayor's proposition. The Missouri university, therefore, declines the mayor's proposition and will build its great medical college elsewhere.

Whether or not the Missouri university will accept an extremely advantageous offer from a Missouri city which has been held in abeyance until the Kansas City matter could be determined—and determined if possible favorably to Kansas City—has not been determined. All that can now be said is that because of the proposition of the mayor denying the guarantee of anything in Kansas City, the building of a Johns Hopkins or Harvard Medical college for the West by the Missouri university in Kansas City is a closed incident."

EXCLUSIVE CONTROL WAS ASKED.

Mayor Beardsley and the council committee would not allow the state university exclusive clinical facilities at the city hospital. The officers of the university refused to consider the question of establishing a medical college here unless the city would guarantee this. The city refused to discriminate in favor of the state university as against all other institutions. The proposition for the establishment of a medical college in Kansas City came from the university originally.

The decision of the executive board of the university was.

reached at a meeting held at the Midland hotel last night. The plan proposed to the members of the board was agreed upon yesterday. It was prepared by Mayor Beardsley, Alderman Baylis Steele and Alderman J. G. Lapp at a conference with John D. Lawson, dean of the state university law school. The mayor and the two aldermen are a subcommittee of a special committee of the council appointed to consider this subject. The plan proposed contemplated putting the hospital under the management of a board of control of six members, not one of whom shall be a physician or surgeon. One section of the ordinance agreed upon by the subcommittee provides that, "the medical departments of the great universities adjacent to Kansas City shall have equal recognition in the appointment of the medical staff." Under this plan the city proposed to retain its control of the hospital. The plan as originally suggested by the board of curators of the university would give the University of Missouri control of the medical administration of the hospital, but the city objected because that precluded the idea of equal clinical facilities to all standard medical schools. That was the rock on which the conference split.

LIST OF FIVE DOLLAR INSURANCE COMPANIES.

The Texas State Journal of Medicine.

The following old-line insurance companies are now paying a \$5 flat rate for medical examinations in the state of Texas:

1. Aetna Life, Hartford, Conn.
2. American National Life, Galveston, Texas.
3. Citizens' Life, Louisville, Ky.
4. Capital Life, Denver, Colo.
5. Colorado National, Denver, Colo.
6. Fort Worth Life, Fort Worth, Texas.
7. Guarantee Life, Houston, Texas.
8. Manhattan Life, New York City.
9. Mutual Benefit Life, Newark, N. J.
10. Massachusetts Mutual Life, Springfield, Mass.
11. National Life, Montpelier, Vt.
12. Northwestern Mutual Life, Milwaukee, Wis.
13. Pacific Mutual Life, San Francisco, Cal.
14. Relief Life, Pittsburg, Pa.
15. Security Trust and Life, Philadelphia.
16. Southwestern Life, Dallas, Texas.
17. State Mutual Life, Rome, Ga.
18. Southern States Life, Atlanta, Ga.

That New Anesthetic.—Reports From the Field.

FAR SUPERIOR TO CHLOROFORM.—The hyoscine-morphine-cactin anesthetic (Abbott) has been entirely satisfactory. In obstetrics it is far superior to chloroform. No nausea, shock or disagreeable symptoms with the mother. The child is born cyanotic but comes round all right. Our county medical society has taken up the matter; all reports have been very favorable. I think it will have a national bearing in the increase of population, as women will cease to dread the pangs of child-bearing, and will increase the number of children born. The nation will owe you a debt of gratitude.

J. S. Dickenson, Trenton, Ky.

TWENTY CASES SUCCESSFULLY.—I have used the H. M. C. anesthetic (Abbott) successfully in twenty cases, full reports of which I have kept, as they were all hospital cases.

J. B. Wright, Trenton, Mo.

JUST THE THING IN MISCARRIAGE.—I find Abbott's hypnotic anesthetic just what I have wanted for some time, and I will keep a supply always on hand. In miscarriage, where the placenta must be removed under anesthesia, they are the very thing and relieve the operator of the worry of chloroform or ether. I believe them superior to the morphine and atrophine hypodermic, as more lasting and certain in effect.

A. D. Barnett, Guilford, Mo.

EXPERIENCE, NOT THEORY, COUNTS.—In the February number you printed an abstract of my reported experience with your hypnotic anesthetic (hyoscine, morphine and cactin comp. Abbott.) Since using the hyoscine, morphine and cactin tablets in a number of different cases I would not be without them. They are valuable in obstetrical as well as surgical work, and in many other cases where morphine or hyoscine is needed. The hyoscine prolongs the rest so well in pain cases that a second dose of morphine is not needed nearly as often.

At the same time there appears to me an unfair and unjust communication in the Journal of the A. M. A. on the subject, with which I most emphatically do not agree.

I do not wish to take back a word that I have said; but I have something to add. Anyone who has used morphine much knows that, although usually one has little worry from its use, occasionally alarming symptoms arise, owing to an idiosyncrasy against the

drug. So, in a morphine compound like this, we must expect annoying symptoms to occur at times.

In using hyoscine, we now and then get marked cerebral excitement instead of the usual nice sleep. In such cases the face is much flushed. I have observed this several times, and I have always been particular whose pharmaceuticals I use. At times I make my own tests, to insure purity; so I know the excitement was not due to atropine or atroscine.

Recently, in an obstetric case, I injected one-half of one of your tablets. Following its use rather marked cerebral excitement occurred. It did not worry me, but to pacify the family I had to administer chloroform somewhat earlier than I usually do.

This will not discourage me in its use, but had the occurrence happened with one not familiar with the action of hyoscine, he would have been much alarmed.

I believe we must be conservative in using this compound, as we are with any other hypnotic, analgesic or anesthetic (and this is the three combined) or any other drug which brings our patient near the danger line.

J. W. Robinson, McCammon, Idaho.

Appendicitis, Hernia and Amputation.

Case 1. Strong, young man, appendicitis. Tried faithfully for two and a half hours to anesthetize him with chloroform and ether and failed. Two days later I gave him one H. M. C. tablet, hypodermically, one and one-half hours before operation, and one-half a tablet fifteen minutes before putting him on the table. Opened the peritoneum when the patient aroused and screamed. As soon as he quieted I had a few whiffs of chloroform given, which he took beautifully, requiring only thirty drops to complete a most successful operation.

Case 2. Woman, aged 50, very frail, femoral hernia strangulated five days. With one tablet, an hour previous to the operation, I was able to complete the radical operation, resecting six inches of gut. This patient took one-half dram of chloroform during the operation, was on the table one hour, and came off very much less shocked and in by far better condition than when she went on the table.

Case 3. Amputation of both feet of a boy for frost bite. Used one tablet and a very small quantity of chloroform. I could mention several other cases, some in the obstetric line, which were

equally satisfactory, but it is useless. I consider the compound the greatest help to surgeons work yet known. Tomorrow I am going to do a thigh amputation with it in a boy thirteen years old, for tubercular knee of months' standing. He is so weak and thin that he could not possibly stand chloroform or ether.

Humphrey Silverton Belt, South Boston, Va.

Three Labor Cases.

We have used your hypnotic anesthetic tablets in three labor cases; they bring the pain down to the lowest possible degree. In one case, where we used two tablets in two hours, we delivered the patient of a ten-pound baby with forceps without her knowing that the child was born or that forceps were used. Her pain must have been nil. One babe had been dead a week before delivery. The other two were born with suspended animation but revived after fifteen minutes' work. Uterine contractions were lessened in each case, although each patient had had ten grains of quinine. We had used the tablets as an anodyne with most admirable results.

C. F. Kercheval, Greensburg, Ind.

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Work of the Council on Pharmacy and Chemistry.

At the Atlantic City Session of the American Medical Association the following resolutions, regarding the work of the council on Pharmacy and Chemistry, were presented by the Reference Committee on Reports of Officers and were unanimously adopted by the House of Delegates.

Whereas, The council on pharmacy and chemistry, after examining many hundreds of preparations, has officially announced its approval of a number of such preparations; and

Whereas, We believe that the editors of many medical journals in this country, both official organs of the state association and privately owned journals, are desirous of co-operating in the work of freeing the medical profession from the nostrum control; therefore, be it

Resolved, That this organization most earnestly request all medical journals to refuse to aid in promoting the sale of preparations which have not been approved by the council, by refusing advertising space to such preparations; and be it further

Resolved, That we most earnestly request the moral and financial support of our members for those medical journals, whether privately owned or controlled by medical organizations, which disregard commercialism and stand firm for the honest and right dealing, thus sustaining the council in its greatest work for the medical profession. Very truly yours,

GEORGE H. SIMMONS, General Secretary.

SOCIETY NEWS.

Dodge City, Kans., June 4, 1907.

Dr. Chas. S. Huffman, Sec'y., Columbus, Kans. Sixth Councilor District Medical Society met on May 30, in the new library building in Dodge City. Owing to rainy weather the attendance was light. Present: Drs. Milton, Whitworth, C. E. McCarty, Thompson and Graves of Dodge City; Hollenbeak of Cimarron, Leslie of Meade, Higginbotham of Liberal and Wilson of Cowley county. Papers: Typhoid fever, by Hollenbeak; Scarlet fever, by Leslie; Results, by Whitworth; and some problems of co-operation by Graves. The discussion was general.

Officers elected for the ensuing year are: President, C. E. McCarty; vice President, Higginsbotham; Secretary, Graves; Treasurer Whitworth. Larned was chosen as place for the fall meeting.

At the conclusion of the meeting the society was entertained by the Dodge City doctors at supper at the Harvey House.

W. H. GRAVES, Secretary.

Fredonia, Kans., June 12, 1907.

Dr. C. S. Huffman, Columbus, Kans.

Dear Doctor:—The Wilson County Medical Society met at Neodesha Tuesday evening at 7:30 p. m. Meeting called to order by Pres. Preston of Buffalo. After the usual preliminaries we came to the reading of the papers. Dr. Addington presented a paper on Summer Complaints of Children. It being a subject in which we are all interested, a lively discussion followed. Most of those present agreed that true cholera infantum is very rare and the mortality very high. At the suggestion of Dr. Allen several members explained in detail just how they would treat a case of acute indigestion and enterocolitis. It showed in a practical way just what to do.

Dr. Moorehead's paper on Potts Fractures indicated that the author had a thorough understanding of the subject.

Drs. Allen and Moorehead invited "de gang" to Dr. Allen's home, where refreshments were served and a very enjoyable hour was spent. Thanks, gentlemen, it makes a fellow feel like meeting at Neodesha again.

The out of town physicians present were: Dr. Preston, Buffalo; Drs. Jones, Addington and Rogers, Altoona; Dr. Duncan, Fredonia, besides Drs. Allen, Moorehead, McGuire, Sharpe, Blakeslee, Day, Jones and C. L. Williams of Neodesha.

Altoona was selected as next meeting place August 13. Papers to be read by Drs. Allen, Rogers and McGuire.

Our county society is improving. Out of 24 physicians in the county, 19 are in good standing, with county and state dues paid for 1907. And we had 13 present at our above mentioned meeting.

E. C. DUNCAN, Secretary.

Year Program Shawnee County Medical Society.

Year Program of the Shawnee County Medical Society, 1907.
Meeting held in National Hotel, Topeka, Kansas.

JANUARY 7.

L. M. Powell, M. D.—Office Diagnosis.

FEBRUARY 4.

H. L. Alkire, M. D.—Some Thoughts Concerning Otitis Media.

D. E. Esterly, M. D.—Discussion.

MARCH 4.

O. P. Davis, M. D.—The Interpretation of Laboratory Findings.

W. D. Storrs, M. D.—Discussion.

Reports and Presentation of Cases.—J. C. Bennett, M. D., E. M. Brockett, M. D., C. W. Schwartz, M. D.

APRIL 1

W. A. Wehe, M. D.—Skin Grafting.

C. A. McGuire, M. D.—Discussion.

Reports and Presentation of Cases.—R. E. McVey, M. D., Geo. Minney, M. D.

MAY 6.

T. W. Peers, M. D.,—Milk Modifications.

N. J. Taylor, M. D.—Discussion.

Reports and Presentation of Cases.—Ida C. Barnes, M. D.

JUNE 3.

R. B. Stewart, M. D.—Obstetrical Hemorrhage.

M. R. Mitchell, M. D.—Discussion.

Reports and Presentation of Cases.—S. T. Millard, M. D.

JULY 1

J. B. Tower, M. D.—Diet in Typhoid Fever.

W. W. Yates, M. D.—Discussion.

Reports and Presentation of Cases.—W. L. Warriner, M. D.

AUGUST 5.

A. Jeffrey, M. D.—Puerperal Infection.

John H. Outland, M. D.—Discussion.

Reports and Presentation of Cases.—J. R. Fay, M. D.

SEPTEMBER 2.

John A. Crabb, M. D.—Laboratory Aids in Diagnosis Practical for the General Practitioner.

S. A. Hammel, M. D.—Discussion.

Reports and Presentation of Cases.—Sara E. Greenfield, M. D.

OCTOBER 7.

S. E. Smith, M. D.—The Static Machine and X-Ray in Country Practice.

Herman S. Judd, M. D.—Discussion.

Reports and Presentation of Cases.—Thos. R. Hyatt, M. D.

NOVEMBER 4.

L. H. Munn, M. D.—Prostatitis.

H B Hogeboom, M. D.—Discussion.

Reports and Presentation of Cases.—C. W. Stahl, M. D., W. E. McVey, M. D.

DECEMBER 2.

Annual Meeting and Election of Officers.

President's Address.—W. C. McDonough, M. D.

OFFICERS.

W. C. McDonough, M. D., Pres. D. E. Esterly, Vice President.

W. A. Wehe, M. D., Treasurer Corbin E. Judd, M. D., Secretary

MEMBERS

Harriet E. Adams	H. L. Alkier
A. S. Andrews	Ida C. Barnes
J. C. Bennett	J. Albert Berry
T. C. Biddle	W. F. Bowen
E. M. Brockett	E. V. Coldren
J. A. Crabb	S. J. Crumbine
O. P. Davis	B D Eastman
F. J. Ernest	D. E. Esterly
J. R. Fay	J. D. Freeman
Sara E. Greenfield	L. Y. Grubbs
S. A. Hammel	H, H. Hazlett
H. B. Hogeboom	G. W. Hogeboom
Thos. R. Hyatt	J. M. Jamison
A. Jeffrey	S. A. Johnson
Corban E. Judd	J. P. Kaster
Otto Kiene	J. P. Lewis
W. S. Lindsay	R. S. Magee
J. C. McClintock	W. C. McDonough
C. A. McGuire	R. E. McVey
W. E. McVey	C. F. Menninger
S. T. Millard	H. C. Miner
Geo. M. Minney	J. E. Minney
M. R. Mitchell	G. J. Mulvane
L. H. Munn	John H. Outland
T. W. Peers	R. S. Plummer
L. M. Powell	W. H. Righter
W. L. Schenck	F. H. Scholle
Chas W. Schwartz	S. E. Smith
C. W. Stahl	Robert B. Stewart
S. G. Stewart	W. D. Storrs
N. J. Taylor	O A Taylor
John Ballard Tower	C B VanHorn
H A Warner	W L Warriner
W A Wehe	W W. Yates

On May 21st over thirty of the members of the Shawnee county Medical Society attended the funeral of one of our oldest and most

highly esteemed members, Dr. J. P. Lewis, who had for some years been our treasurer, and had always been an enthusiastic supporter of everything tending to encourage and dignify our profession. His death, after a lingering illness, leaves many saddened hearts among the profession in Topeka.

The regular monthly meeting of the Shawnee county Medical Society was held in the National Hotel at Topeka on the evening of June 3rd, with Dr. C. W. McDonough, president, in the chair, a large number of members in attendance, and one visitor, Dr. Munford, of Topeka.

Dr. Millard, who was expected to present some clinical cases, was absent, and the society proceeded to the paper of the evening by Dr. Robert Stewart. This was a live and carefully prepared discussion on "Obstetrical Hemorrhage." He considered it under the headings—Abortion, Accidental Hemorrhage, Placenta Previa and Post Partum Hemorrhage. The keynote of Dr. Stewart's paper was "to save all possible blood for the mother." He dwelt at length on the appropriate treatment for each condition. A lively discussion followed, led by Dr. Wehe, participated in by all present, and closed by Dr. Stewart.

The application of Dr. C. M. Hensley of Topeka was favorably reported on and he was admitted to membership by unanimous vote.

J. B. TOWER, Sec'y.

Report of Marion county Medical Association for January 11, '07.

Owing to the absence of the President, Dr. McIntosh, Dr. Wathinu acted as temporary president.

Secretary's report read and accepted.

Treasurer's report received.

Moved and seconded that Harvey county Medical Society be notified by secretary that their society should not receive any dues from physicians living in Marion county.

Election of officers.

President, Dr. Myers; Vice President, Dr. Furst; Secretary and Treasurer, Dr. Mayer; Delegate to State Society, Dr. Marimer.

Board of censors continued.

Dr. Myers read a paper on Pneumonia. Discussion by members.
Adjourned.

R. C. SMITH, Sec'y.

ABSTRACTS.

A TYPHOID FEVER DISTRIBUTOR.

G. A. Soper, New York City Journal A.M.A., June 15), gives an interesting account of a series of family epidemics of typhoid, all associated with the presence of a single person who seems to be a chronic carrier of typhoid germs. The first attention was called to an outbreak of typhoid in a family at Oyster Bay, N. Y., in which six out of a household of eleven were attacked. A most thorough investigation revealed no cause, until on careful inquiry it was found that the family had engaged a new cook about three weeks before the outbreak, who left them about three weeks after the appearance of the disease. When, after much trouble, her whereabouts was discovered, she refused to give any account of herself whatever, but a partial history was obtained from other sources. For two years of the last five there is no record of her doings or residence. It was positively ascertained, however, that in the last ten years she had worked in eight families and in seven of these typhoid followed her, in the majority within a few weeks of her coming. The one exceptional case was a family consisting only of two persons of very advanced age and one old servant. In no case was the cook herself a victim. Details are given of most of these outbreaks. The attention of the New York Health Department was directed to the case after these facts had been ascertained, and much against her will, she was sent to the Detention Hospital. In fact she showed remarkable strength and agility in resisting arrest. Bacteriologic examinations made in the department laboratory showed typhoid bacilli in great numbers in the feces of the individual and the blood gave a positive Widal reaction. Dr. Soper thinks we have in this case a striking example of the chronic typhoid germ distributor.

SCOPOLAMINE NOT HYOSGINE!—A CAUTION.

The Achivuer Gynaekologie Steffen gives some interesting details as to the use of scopolamine-morphine by Leopold. The latter has employed this method in three hundred labor cases. His verdict is that the method does not accomplish the desired results, it cannot be regarded as harmless for mother and child, and in private practice the by-effects liable to develop may render medical aid requisite at any moment. When men come to conclusions so opposite as those of Leopold and those reported by Gauss, we, to whom each observer is equally trustworthy and free from bias, can only attribute the diversity to a different technic. That this is so may

be seen by Gauss' examination of Hocheisen's method. Gauss secured a specimen of the solutions employed by Hocheisen and tried them in ten cases, the result being far worse than those reported by Hocheisen. Every objection raised by Leopold has been examined and disproved by Gauss in his much larger experience. Weakness of the labor pains did not occur to any material extent, more frequently or more markedly than in cases where this anesthetic was not used, nor were version and forceps required with greater frequency. The vomiting could only have been accidental, since it did not occur in Gauss' cases, excepting when it had commenced before the anesthetic was given. So also to the perils to the child. Gauss showed that the mortalities of both mother and child were much less than they had been before this anesthetic was employed.

The extract, as presented in The Journal of the American Medical Association, gives palpable evidence of anxiety to make out a case against this anesthetic method. Even Gauss is made to rank as an objector to the method, by quoting eight troublesome cases which occurred out of his one thousand; just as if such things never happened unless scopolamine was employed. To any one who wants the whole truth, and not a garbled expatire statement, we refer to Gauss' statistics as given by Holt, in the May number of the American Journal of Clinical Medicine. But even were the account given a fair one, the reader will note that it nevertheless relates to the use of scopolamine, which, as commercially presented, is not the same thing as the hyoscine used in America. It is much as if men should insist that, because Germans injure themselves drinking too much beer, we in America should abstain from coffee.

The above being the gist of our knowledge of this subject to date, and the therapeutic difference between hyoscine, a true alkaloid, and scopolamine (so-called hyoscine from scopola—a serious error of nomenclature) a mixed, uncertain product, being well established in favor of hyoscine, we caution our readers who are interested (and all should be) to use only H·M·C Abbott (hyoscine, morphine and cactin comp) the original American product and one which like all the Abbott line, may be depended upon.

BOOK REVIEW.

Surgical Diagnosis. By Daniel N. Eisendrath, M. D., Adjunct Professor of Surgery in the Medical Department of the University of Illinois (College of Physicians and Surgeons). Octavo of 775 pages, with 482 original illustrations, 15 in colors. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, \$6.50 net; Half morocco, \$8.00 net.

This book, like the author's surgical anatomy, is characterized by fullness of illustration and attractiveness of form. The subject is studied regionally and from the clinical standpoint.

On those subjects with which the author has considerable personal experience his writing is interesting and complete; but his general fault is a lack of detail and exactitude of statement in matters which either he considers unimportant or lacks exact knowledge. Hence the book is not an encyclopedia, but a monograph giving the experiences and views of one teacher. Since, then the author does not add to the sum of our knowledge of surgical diagnosis, his book is to be judged from the standpoint of the text book for students. For this purpose it should summarize and put into attractive form for beginners our accumulated knowledge of surgical diagnosis. This, we believe, the author has done quite successfully, and we commend the book to Kansas students.

The author's chapter summarizing the blood findings in surgical disease will be found of great help for reference. He gives also the technique for opsonic index studies, cystoscopy, ureteral catheterization, cryoscopy, etc.

A Practicians Hand Book of Materia Medica and Therapeutics, based upon established physiologic actions and the indications in small doses. By Thomas S. Blair, M. D., Pittsburg, Pa. 253 pages, bound in limp library cloth. Price \$2.00 net. Published by the Medical Council, 4105 Walnut street, Philadelphia, Pa.

This book is an index of the present condition of the science of pharmacology. For we are realizing that the traditions of the fathers are practically all half truths, and that it is unworthy of this age of advancement to accept with blind credulity the dicta of either Hahnemann, Scudder or Sydenham. We are finding that each of the various methods of practice has had its modicum of truth and are therefore willing to associate with and be taught by those who have been reared to revere a different therapeutic creed. Dr. Blair has brought together in this little book concise notes on all the drugs employed by successful physicians, be they sectarian or regular. The book will be very helpful to him who does not care to study the pharmacology of drugs by the newer

scientific methods, but who does want to know the empirical views on each drug.

Pharmacology today is a new science—adapted just as much to the worshiper of a historic Hahnemann as to a disciple of Galen. Its aim is to ascertain the active principles found in our *materia medica* study, their actions on animals and healthy men and thus deduce rational uses for each. This study has shown us that we have been using in drugs called by very different names active principles practically identical and varying only in force of action. Thus we find that atropine is paradigm for a whole category of vegetable preparations to which were ascribed the wildest variety of influences and actions.

The result of this increasing knowledge is that the better trained men are gradually decreasing the number of drugs employed and are using this smaller number with greater discrimination and accuracy. A study of the chapter on coal tar derivatives in Sollmann's *Pharmacology* cannot but lead the open minded physician to use a smaller number of those products. Similarly the atropine series carefully studied will cause one to use atropine in varying doses for bryonia, gelsemium, etc. Even aconite will give place to drugs with more selective action.

We, therefore, believe that while Dr. Blair's book will be found helpful in showing the uses of the multitude of drugs now on our lists, nevertheless the study of a modern text on pharmacology (such as Sollmann's) will do more to clear our minds of confusion. When this occurs we hope that our state boards will not persist in asking recent graduates questions on drugs about which they have never been taught, and which have only a historic interest.

Modern Surgery. General and Operative. By J. Chalmers DaCosta, M. D. Professor of the Principles of Surgery and of Clinical Surgery in the Jefferson Medical College, Philadelphia. Fifth revised Edition, enlarged and reset. Octavo volume of 1283 pages, with 872 illustrations, some in colors. Philadelphia and London; W. B. Saunders Company, 1907. Cloth \$5.50 net; Half Morocco \$7.

This work first appeared in 1894 and gained for its author wide recognition. This makes the fifteenth reprinting of the work. This one fact is sufficient evidence of the popularity and success of the book. Its style is pleasant—the diction clear—and the statements concise. Therefore it is a book of great value to the student and general practitioner. The present edition is up-to-date, in that the latest suggestions and discoveries have been considered in the re-writing. Of course the value of such a summary of methods of

work depends upon the good judgment and learning of the author. Dr. DaCosta seems to hold such a high place in the good opinion of the surgeons of America that we may with safety consider the statements made in the book authoritative.

Principles and Practice of Medicine. A. R. Edwards, A. M., M. D., Professor of the Principles and Practice of Medicine at Northwestern University. A book of 1328 pages, 191 engravings and 19 colored plates. Lea Bros., Philadelphia.

The arrangement of the subject matter is admirably adapted to the physician who is hunting for a special topic; the size of the type in the headings quickly attracting the attention to the topic desired. The use of italics calls the attention of the student to the essential points which he might otherwise miss.

The author reflects the present tendencies when he devotes less space to pathology and more to treatment and the use of drugs. Indeed one questions whether in the use of so many prescriptions and formulae and the extended descriptions of the physiological action of drugs he has not encroached on the province of *Materia Medica* and Therapeutics. The use of pathology to explain symptoms is relegating pathology to its proper place in a text on medicine, and the space thus saved is well filled by the elaboration of methods of treatment. It seems to the writer that the schematic tabulation of symptoms for differential diagnosis is a distinct advance. By means of these tables the busy man may more easily run down and settle the diagnosis of a puzzling case when the symptoms of similar diseases are all before him on the same page.

Diagnostics of the Diseases of Children, by Le Grand Kerr, M. D., Professor of Pediatrics in the Brooklyn Postgraduate School. Cloth, royal octavo, pp 542. Fully illustrated. Philadelphia: W. B. Saunders Co., 1907.

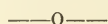
We commend this book unreservedly to our readers as being one of the most practical and helpful books on this subject coming to our desk. The paper is of the finest quality, hence the type and illustrations appear to good advantage. These illustrations are not mere ornaments—they are helpful.

The style is objective hence the authors' statements are clear. Evidently he has studied children at first hand long enough so that he does not need to compile his text book from pre-existing text books.

Under the acute exanthemata the author makes no mention of the "fourth" [Filatow's] and from his general remarks we infer that he regards errors in diagnosis as so common that we might just as well remain by the good old fashioned classification as to

seek a new one. In Kansas City all this spring (1907) there has existed an epidemic of measles and coincident with it (not of course in the same patient) an evanescent illness wherein the temperature for two days plays about 104, the face is flushed scarlet, a severe bronchitis exists, and then after the fever subsides a coarse desquamation ensues. Local physicians have called it the fourth disease. Some cases have been diagnosed as scarlet fever. Our author would call it either an acute urticaria or scarlet fever, we judge.

The author's technique of examination is clever and well described. His use of the double tape in measuring the chest, his directions for using the binaural stethoscope are all so good that we wish the coming generation of physicians could all read the book.



Nutrients.

Nutrition spelt with a big N should be one of the largest words in the vocabulary of the physician. The weak, the delicate, and those who are below par from overwork or imperfect development should be nourished often times to the point, almost we were disposed to say, of "stuffing." Of course the proper nourishment of our patient at all stages of disease is important, and in the acute period for a time the proper nutrition really means judicious starvation or the withholding of food until the digestive tract can be placed in a condition to do its work. Beef tea, time out of mind, has been one of the chief standbys of the sick room, but as a matter of fact we know now that which should have known long ago, that the average beef tea is a fraud, and that it is no more nutritious than a weak toddy would be; that it is practically nothing but water with a few soluble salts of the beef contained therein.

The only way that we can hope to give the elements of nourishment in a concentrated form, represented by beef fibre, is to order a commercial extract of beef, and in doing so we should be sure that the product which we order is made by a skillful pharmacist. The Charles N. Crittendon Company has for many years been furnishing to the profession a most efficient product of beef under the name of Colden's Liquid Beef tonic, which is most valuable in all forms of wasting diseases and in cases of convalescence from severe illness. It is indeed a food medicine, which is promptly assimilated and which interrupts and prevents the breaking down of vital tissues; and one great advantage to the patient is that it is agreeable to the taste and acceptable to the most delicate stomach.

Officers of County Societies for the Year 1907.**FIRST DISTRICT.**

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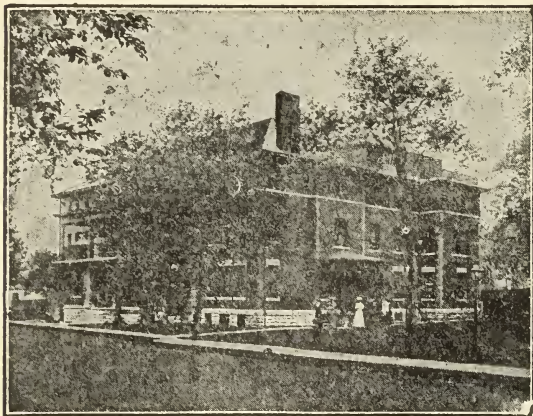
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Dr. W. Harpur Sloan, Chief of the Ear Department Medical-Chirurgical Hospital, Philadelphia, Pa., speaking of the importance of tissue building recently, said that every physician has at some time in his professional career, become discouraged in his ability to treat successfully cases of mal-nutrition, wasting diseases, and kindred ailments that have failed to respond to the ordinary tonic treatment so much in vogue among us.

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ORGANO-THERAPY IN THE TREATMENT OF NEPHRITIS.

By DR. E. J. LUTZ, Kansas City, Kansas.

Before essaying to write upon the subject of organo-therapeutics in the treatment of Nephritis at the present day, it is quite necessary to define, along certain lines, one's conception of the scope and application of the term.

Organo-therapy or opo-therapy comprises the science and art of healing in the use of juices, extracts or secretions derived of certain organs or parts thereof, which are taken from the animal kingdom, for the purpose of alleviating and curing disease. They are, to some extent, composed of inorganic materials, as water, gases, salts, etc., but chiefly consist of organic compounds (proximate principles) obtained by a proximate analysis. The further reduction of these proximate principles to their elementary constituents shows that carbon plays the leading role therein, associated with hydrogen, oxygen, nitrogen, and other elements.

The use of glandular extracts and juices as remedies in disease is very old, and by no means of recent origin, as is commonly supposed. The organs, tissues, and secretions of animals were extensively employed as medicinal agents in ancient times. According to Park, the treatment by organo-therapy may be traced to a very early epoch in the history of medicine. Chinese physicians have used since remote antiquity, the juice of macerated pigs' lungs for pulmonary diseases; for headache, pigs' brains were administered;

Read at the forty-first annual meeting of the Kansas State Medical Society, May, 1907, Kansas City, Kan.

for dysentery and chronic diarrhoea, pigs' intestines. Many of the glandular extracts and juices were official in the pharmacopoeias of the last century. At present the only glandular extracts recognized in the United States pharmacopoeia are the supra-renal and thyroid glands of the sheep.

In 1889 Brown-Sequard advocated the use of orchitic (testicular) extract for impotence and several nervous affections, and was profoundly stimulated by the results of Murrays' suggestion in 1891 of thyroid extract for the cure of myxedema. According to his theory all glands, in addition to their ordinary secretions, elaborate certain materials of unknown chemical composition, which pass into the blood and perform therein definite functions of some kind. We know now that such is the case with the thyroid and supra-renal glands, and we suspect that it is equally true of the thymus and the spleen, and have reason to believe it highly probable that the other glands of the body exert influences heretofore unsuspected, over distant parts of the organism.

Potter says that the animal extracts form a group of active medicinal agents, which are worthy of careful investigation, both physiologically and clinically. The study already given to them has yielded much new knowledge, and has shown indubitably that their employment as therapeutic agents rests on a scientific basis. But most of them are, as yet, on trial and the limits of their utility in medicine are by no means defined. They are active medicinally only when injected subcutaneously or by the rectum, with the exception of thyroid extract and perhaps some others. Most of them are destroyed or altered in the stomach, or prevented by the liver from entering the general circulation. Physiological chemists are endeavoring to separate their active principles, some of which are already demonstrated to be the most powerful of all alteratives, while others possess the most energetic action upon the muscular fibres in the walls of the arterioles.

It cannot be denied that the use of the extract or juice of some of the organs have certain disadvantages on account of the varying amount of active substance in the individual organ, the admixture of products of decomposition, etc. Obviously it would be desirable to isolate and to utilize the specific active substance. There have been numerous trials in this direction. At one time it was hoped that the desired body could be obtained in the form of a ferment, at another time it was supposed that it could be secured as a fixed chemical combination from the group of proteid substances or even as an alkaloid.

Of the organo-therapeutic specialties, thyroid and supra-renal extract are the ones mostly used and talked of. The renal extract or nephrine belongs to the newer extracts, and is beneficial, especially in renal diseases, in affections arising from impairment or failure of nitrogenous metabolism, the promotion of which is one of the functions of the kidneys.

Other organic extracts and preparations are also known to produce certain effects upon the organism. For instance, thus adrenal extract increases blood pressure, preparations made from the spleen and liver have an influence upon leukocytosis. Successes are reported with cerebrin in cerebral affections, medullin, in diseases of the bone, with didymin for subjects of impotence or a debilitated nervous system, with the substance of the adrenals in Addison's Disease, with pancreatic tablets in diabetes on account of the experimentally proven relation of the pancreas to glycosuria, and diabetes. All these later named, when examined, are based upon nothing more than analogy and lack direct experimental proof in general and the successes reported with these preparations must be regarded as very exceptional, if, indeed, we credit them at all.

Krusen in 1901 reported that he used ovarian extract in 100 cases of amenorrhea and other pelvic disorders. While he met with some striking results, on the whole, the treatment proved a failure and no definite reliance is to be placed on the agent. No benefit was seen in amenorrhea and dysmenorrhea, but better results in the artificial menopause. It was, however, harmless. The use of the agent is based on a false theory, since the ovary is not a secreting organ.

Several years ago Ghedini made experimental researches on organ treatment. He injected dogs and lambs subcutaneously with extracts of various organs, continuing the treatment from one to several months. He then found evidences of inflammation of a degenerative and infiltrative type in the superficial lymphatics, especially those in the axilla and inguinal regions, and in the liver, kidneys and spleen, while the thyroid gland was in a condition of hyperfunction. No other reaction could be discovered. These results were constant in his fourteen animals, and he assumes that the organ extracts acted like toxins in the circulation, without any specific affinity for the corresponding organs. Later on he made experiments on a second series of animals with like results.

In the field of organo-therapy the same phenomenon is met with which we find at present in other realms of therapy; professional activity and choice are influenced more than is desirable from a source outside of the profession. I mean by the manufacturing

chemist. The chemical laboratories have lately thrown themselves jealously into the endeavor, laudable in itself, to produce or to combine chemical bodies, whenever a theoretic consideration, or an animal experiment appeared, to show the existence of a pharmacodynamic property. These endeavors have flooded the medical market with an endless number of new preparations, that are distributed for trial, and with the hope of a successful trial, to competent and incompetent judges. Now, there is absolutely no curative agent, no matter how slight the foundation for its use, that does not have its firm believer, and serve for purposes of investigation.

These facts every fair minded physician will admit as only too true, and so it came that during the last ten years I busied myself during leisure hours, with organo-therapy, taking up principally the kidney. In treating different types of nephritis, especially serious uremia, the final stage of complete renal insufficiency, we should have only one object in view: to moderate toxemia, the obligatory result of glandular impermeability, by facilitating the elimination of the retained poisons through the agency of the natural emunctories, or by endeavoring to withdraw them directly from the blood in circulation. This can be accomplished by endeavoring to arouse the renal eliminatory function by means of diuretics or cardiac drugs, or by bringing into play certain alternate functions by the use of purgatives, sudorifics, or by the more radical method of blood-letting, or lumbar puncture, or, lastly, by the use of opotherapeutic treatment, to neutralize these poisons directly in the blood or in the tissues impregnated with toxic edema. Of this last named treatment, opotherapy, I shall speak more fully.

Organo-therapy in diseased conditions of the kidney, more especially uremia, has been used during the last fifteen years in this country; the physicians in foreign countries have done likewise. The reason why renal organo-therapy has not yet entered into our ordinary practice is that we were inclined to demand greater results from it than it is capable, strictly speaking, to give. Experience has shown that, when used at the proper time and under clearly defined conditions, it has unquestionable indications and efficacy. When using the organic treatment in Nephritis we have two points to consider:

First: The conditions warranting its use and what hopes we can found on it.

Second: The rules that are to guide us in choosing the preparation to be used.

In a general way I will say that the organo treatment finds its

application in all cases of renal insufficiency of whatever importance, acuity or significance and will be only of real value and service in counter-balancing the toxic effect of retention products until such a time as the treatment employed shall have again opened the channels of excretion, re-establishing in the permeability of the gland the relative equilibrium that has been upset by the disorder present.

Professor Teissier in the International Clinic mentions the three different methods which have been followed in endeavoring to compensate the failing renal function and to replace the suppressed internal secretion.

1. **The Glycerin Extract of Kidney Tissue, Called Nephrine.** Made as follows: The kidney of a pig is carefully extracted in a sterilized vessel. Then cut into thin sections, macerated in an equal amount in pure glycerine and packed in a vessel set in ice. At the end of twenty-four hours the glycerine has extracted from the macerating kidney thirty per cent of its juice. The extract, to which from five to ten parts of chloridized water is added to make the injection less painful, remains two hours in a d'Arsonval's sterilizing filter under 60 atmospheric pressure of carbonic acid gas, and is then filtered through a d'Arsonval porous candle at the same pressure. The liquid, when filtered, comes out perfectly limpid, and is enclosed in bulbs sealed by a blowpipe. Each bulb contains per C. C. all the soluble elements of from ten to twenty-five centigrams of renal substance, according to whether the original glycerine extract was diluted in five or ten parts of salted water. Teissier prefers the five-part solution for therapeutic use. Age appears to have little effect on extracts prepared in this manner. Keep on ice and as long as the liquid remains limpid it is good for use.

2. **The Blood Serum Extracted from the Renal Vien.** Bra in 1895 was the first one that broached the subject by querying "whether the blood, leaving an organ, and which contains, consequently, the products of internal secretion of that organ, would not act more usefully than an extract made from the entire organ." This serum is extracted by aspiration from the renal vein of a goat, an animal that is usually refractory to tuberculosis, and whose serum is slightly toxic—less than that of man. Twenty C. C. of this is injected under the skin of the abdomen two or three times a day as long as necessary. The injections are always well borne, although, after causing temporary rise of temperature, in some cases even severe, the thermometer rising to 102 to 104 F., during the day following the injection. This rise of temperature is always noticed in fresh serum and as it loses its toxic action with age, without losing its anti-

toxic properties, which it retains for many months after extraction, we feel that it is preferable not to use fresh serum.

3. **The Direct Use of the Pulp of the Raw Organ** in giving by the stomach a maceration of the entire gland, the integral opotherapy. Remove the capsules of two or three pigs' kidneys, wash thoroughly, and cut up fine and mash in a mortar; to the pulp thus prepared, add 450 grammes of water salted to seven per cent, macerate for four hours, then decant carefully. This liquid, about three to four cupfuls, contains the greater part of the really useful glandular elements; given in a little milk or bouillon in three or four doses.

I have used the glycerin extract, in the last five years, in about fifteen cases suffering from chronic nephritis of from four to eight years standing. All of these cases were complicated with serious signs of auto-intoxication, stubborn headache, giddiness, obscuration of the visual field, vertigo, somnolence, gastro-intestinal derangement, combined with nausea and vomiting, slight edema of lower extremity, more so at abdomen, a very large decrease in the total daily excretion of urinary solids, and with partial or complete unconsciousness, accompanied with convulsions beginning in one extremity, face and muscles of the neck. In several cases the muscles of chest and abdomen were involved and patient complained with asphyxia and dyspnoea. In eleven cases, after using the organo treatment, the above described condition subsided, the urinary solids increased and all auto-intoxication signs disappeared. This took about two to three months, according to the severity of case, the other four cases had absolutely no benefit, as the partial recovery only lasted a few days, or even a week, after which the patients grew as bad as before, in spite of the opo-therapy and finally succumbed.

The initial dose of this extract should be very small in order to avoid the possible systemic disturbance, which I have noticed as following on its administration. I generally began with one to one and one-half grammes twice daily, increasing it to two C. C. after a few days.

The blood serum extracted from the renal vein, I tried in five other cases where the glycerine extract injection seemed to fail. Two of these cases followed scarlet fever, one typhoid fever, one diphtheria and the other one had no history. The last case had an acute nephritis with an unknown exciting cause, lasting six weeks. After a supposed recovery the patient became ill suddenly and in twenty-four hours became edematous all over the body, complete anuria, massive albuminuria, intense headache and backache, gas-

tro intestinal disturbances with constant vomiting and intense cerebral symptoms. The other four cases had about similar symptoms, only coming on slower. The nephrine injection failed to give relief in all five cases, while the serum gave relief in all cases with the exception of the one following diphtheria. This patient died five weeks after a supposed recovery of diphtheria from a post-diphtheritic paralysis. In the four cases mentioned the albuminuria disappeared almost completely. On the third day the urea and chlorid elimination increased and urinary toxicity decreased.

The macerated pulp of the raw organ was used in thirty cases, giving about two sheep or pigs kidney daily for ten consecutive days, stopping one week and then taking the same treatment over again as before. The symptoms of these thirty cases were along the same line as mentioned above, only the functional insufficiency of the kidneys was not so well marked. All of the cases were male patients from thirty-five to forty years of age. Twelve could not overcome their repugnance at swallowing this preparation, and stopped after trying to use the maceration, without any benefit. Five had very serious gastro-intestinal disorders accompanied with intense vomiting and purging, three others manifested urticaria, which made it necessary to abandon the treatment after many unsuccessful trials, as the same condition always reappeared when taking the treatment. It was only possible in ten cases to overcome the initial distaste to swallow this preparation. In three of the ten cases the symptoms of albuminuria became so much worse that the administration of the glandular maceration was also stopped. In the other seven cases the urine showed progressive decrease of albuminuria, while the symptoms of renal insufficiency disappeared completely in two cases, while only partially so in five.

During my observations, I came across three cases of blindness in the course of severe nephritis with uremic symptoms where the extract was used. In two of the cases I noticed pupillary reaction was present and the patient recovered from the blindness, while on the third patient I didn't notice any reaction of pupils and permanent blindness resulted. I attributed this condition to the great pressure of exudate ensuing in a degeneration of the optic nerve, while in the transitory blindness the optic nerve recovered again completely.

In summarizing my observations I believe that renal opotherapy is surely of real service in counter-balancing the toxic effects of retention products until such a time as the treatment employed shall have again opened the channels of excretion, re-establishing in the

permeability of the gland the relative equilibrium that has been upset by the disorder present.

No matter how diverse the different organo-therapeutic preparations may be, their use evidently checks the previously described symptoms of renal insufficiency to a large extent, which give place to decided improvement and in some cases, almost complete health; therefore, all must contain more or less some active substance or principle, though perhaps some more than others.

At times the remedy becomes unnecessary, and it may be discontinued for a considerable interval, because a certain reserve accumulates, which, after the cessation of the specific therapy, is only gradually utilized and consumed by the organism. Again, in other cases, after discontinuing the administration of the remedy for sometime, we may have to return to it as signs of renal insufficiency always recur.

This is not to be wondered at, as our substitution therapy does not root up the soil, but only re-supplies some necessary products of metabolism. For this reason the medication must be persistently carried on from time to time, either in using the glandular extract, although it has no action on the actual working of the kidneys, against toxic symptoms, or in injecting the renal vein serum which is more active and efficacious, especially in cases threatening life, when we have to get action quickly. The glandular maceration has various drawbacks, which depend unquestionably on the presence in the liquid absorbed of toxic substances, elaborated or condensed in the glandular cells, and which sterilization of the product of maceration, or its filtration under pressure might remove.

In conclusion, I will say, this branch of renal organo-therapy in whatever form it may be applied, is a therapeutic method that physicians will do well to use. It is firmly based on observation and experience, but it requires additional research, which should be conducted patiently and seriously and without sensational notoriety.

We all recognize the fact that in the past the medical profession has had to depend in large part on its own unaided and unendowed efforts, when it wished to advance medical knowledge. This self-sacrifice of the profession will probably keep on to point out the paths along which research should proceed to yield the most important results in the immediate future.

DISCUSSION.

Dr. Bolton:—I want to compliment the doctor on his paper. He is getting into therapeutics and that is the subject in which we are all in-

terested. We need therapeutics, whether it comes in the chemical line, the vegetable, or the animal. We want to know what these things are. I have learned something from the doctor's paper. There is no question but organo-therapy is in its infancy. There is no question but organo-therapy will be given a larger place in medicine. The efficacy of the thyroid gland is established. Even the surgeons will grant that point. Theoretical organo-therapy is based on a scientific platform. I believe the time is coming, and not very far distant, when we will have more of the organic extracts.

Dr. Kasey:—This paper interested me particularly because I happen to have a case of chronic Bright's Disease at this time. We are all aware that heretofore our treatment of chronic kidney troubles has not been as successful as we would like to have it. I have just begun the treatment of this case. There are all the symptoms of Bright's Disease; and, I have placed the patient on a treatment somewhat similar to what the doctor describes. I hope to get some good results; that I may have a favorable report to make to this society at some future meeting. This paper itself has fully repaid me for coming to the society.

Dr. Hayes:—I am not prepared to discuss this paper. I just want to express my unqualified appreciation of it. In regard to the percentage of cases where the doctor observed great benefit, they may no doubt be accounted for by the pathological condition. I notice he does not advocate the administration of ovarian substance on the theory that the ovary is not a secreting organ. I should like to know why it is that such profound changes occur in the system after the ovaries are removed.

Dr. Blasdel:—When the doctor spoke of the ovary, the thought occurred to me of the thyroid gland. We have the thyroid extract. The internal secretion of the ovary is explained by some pathologists.

Dr. Lutz:—Mr. President, Ladies and Gentlemen: The first speaker mentioned organo-therapy is still in its infancy. It is not still in its infancy, because Chinese physicians made use of it. I do not see where its infancy comes in. Antitoxine was first used in a children's clinic in more modern days. They used it carefully; and, they had results. When we had our first medical meeting, and I advocated the use of antitoxine, that they did not throw me down the hall was all. But the same gentlemen are using it now. That got me started along the line of organo-therapy. In the use of this serum, I want to tell you that it does not take very much. Sooner or later some of you will have a case of scarlet fever when complete anuria is there. You try to get that kidney to secrete and you cannot do it; and, life is almost ready to leave. The best thing to do is to get a goat—make an incision along the spinal column, go right in and get the kidney. You extract that blood. You collect the blood in a basin that is completely sterilized, run it through a strainer that is absolutely clean, inject that; and, you can chop my head off if you do not get results. When all the internal remedies fail, it is successful. Three years ago I was called out in the country six miles. I had nothing with me but a few drugs. I found the child as described. The only instrument I could find was a razor. Chloroform I did not have. The only thing was to tie the goat down and have the armers hold it. This we did. We got the blood; and, with a hypodermic

syringe, I injected it, serum and all. The child got well. Gentlemen, there is something in that. If you have a chance to use it, use it. I do not mean to say that this serum is for the purpose of bringing back life, or restoring the destroyed cells. But it is effective until your other remedies can get started, to get the skin to act, the bowels to act, etc. For its use in Bright's Disease, it is not a cure, it simply tides a patient over until he is able to get out and get fresh air and exercise, and so prolongs his life. It is a cheap method—a goat only costs about \$3.00. They are always handy. Only remember that if that extract is used immediately after taking from the goat it raises the temperature from 102 to 104 degrees; while, if you let it stand three or four days, it will not do that. I am using it now on a case. As to your question about the ovary; I do not know anything about it. I only speak of the kidney. I simply mention that these extracts are used.

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Pennsylvania Medical Journal.

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Congenital Cataract.

Edward Stieren (Ophthal. Rec., May) reports out of a family numbering 78, 18 cases of congenital cataract. All the subjects died in infancy or within a year after birth. Each married female in the family group, with one exception, had one or more blind male offspring. The transmission being always from mother to son (never from mother to daughter, and never from father to son or father to daughter), it is evident that the male progenitor could not transmit the stigma to his son, but could transmit the tendency to his daughter, in whom the degenerate physiologic units combined, to be visited upon the son.

SYMPTOMATOLOGY OF RENAL COLIC.

By DR. W. T. GROVE, Eureka, Kansas.

Upon solicitation of a member of your committee, I decided to read a paper on renal stone, renal colic, and more particularly its symptomatology.

It was during the summer months of 1905, in the Chicago Clinical school in a conversation with Dr. Weiner, one of the staff surgeons with whom I was conversing, talking of my experience with a three month's siege of renal colic. When I was through describing my case he urged me by all means to write it out and publish it as he considered it a very important aid in summing up the symptoms complex, duration and the final passing of the stone which was conclusive evidence of the correct diagnosis.

During the early fall of 1898 one Sunday afternoon less than an hour after dinner, while strolling over a cornfield near my farmhouse adjoining town, I was siezed violently with a colic pain in the left side. It commenced in the region of the left kidney. I had symptoms of an acute desire to try to urinate, then a great desire to defoecate. I tried to do both and in the effort I became suddenly nauseated and vomited my whole dinner. The pain showed no desire to abate. I crippled along to the house in a half bent manner and had my sister-in-law apply hot applications. This would make the pain radiate. If the heat was put over the kidney it would radiate to the fellow testicle—by applying heat over the testicle it would radiate up the ureter and in the left lumbar region and when heat was applied to the side and lumbar region it would again descend to the testicle. Thus you could chase it in a cycle as it were, with the heat. The heat quieted the pain somewhat and it was then I called for a spoon and some sterile water. I prepared an eighth grain of morphine and injected it hypodermically. In an hour or so with the aid of this and heat it abated some, and after relieved to a bearable degree, I proceeded to visit a case of meningitis. Before I left the house I told the nurse my intense suffering and she injected $\frac{1}{4}$ grain of morphine. This was about three hours after the first injection. In half an hour I was almost quiet. I went home and remained in bed all night.

I got up as usual Monday and went to the office. I had to make

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a call in the buggy in town. Just as I made the effort to get in the buggy I was again violently seized. Hastily making the visit, I ordered the driver to take me to my office assistant's residence, my own family being away visiting. Her sister being a trained nurse, she proceeded under instructions to use heat and morphine. I passed a very restless and painful night at intervals. The next morning I got up and went to work as usual and was suddenly seized again with the same chain of symptoms. This was even more violent in character. The same therapeutic routine was repeated. Drops of sweat as large as a pea came out all over me and her father said I must have a physician. I told him I was doing all any one could to relieve the pain, and nature was trying to push it through. At any rate, Dr. Basham, then of Neal, and now of Wichita, was summoned. He was sixteen miles away, and having to wire, by the time he came I was easy and up. I turned over my patients to him to look after temporarily. By this time my family had arrived, having been summoned by wire. We went home and a very peaceful night was passed.

At eight o'clock next morning I was summoned to see another patient in town. I started. Just as I was putting on my vest I was seized apparently more violently than ever. I got down in bed and with the constant use of heat chasing that pain from the left lumbar region over the ureter and to the testicle, then back, etc., also being under $\frac{1}{4}$ grain doses of morphine, I suffered for nine hours without any apparent ease. When relief came it came as suddenly as it commenced. I was very weak, remaining in bed a day or two, suffering with intense backache and apparently no action scarcely from the kidneys. The first urine contained microscopic blood, urination was almost next to impossible. I made a slow but gradual return to normal.

In 1903 I had considerable swelling of the lower limbs, carried almost constantly a specific gravity of 1028 to 1030 or 1032, suffering a reduction of 60 per cent normal sufficiency, accompanied at intervals with violent sick headache. In May the following year during sleep about 2 a. m., I was aroused with a violent pain, at first like the left kidney was full. It kept growing worse until I had to resort to heat and morphine. This was about the middle of May, 1904, or nearly six years from the first attack. This attack did not last long, but in two or three days it renewed itself with energy and became violent. These attacks were of rather long intervals, lasting from 24 to 36 or 48 hours.

I decided to attend the American Medical Association in June

at Atlantic City. This was during the World's Fair year, and sleepers were in much demand. It was my luck to have upper berths and it seems that a car ride would precipitate an attack. The attack during the second siege would commence with an ache in the left kidney with a feeling of fullness gradually increasing until the colic character came on. I was seized on the sleeper between Kansas City and St. Louis about 3 a.m. I resorted to morphine and got considerable relief, but from this time on I felt constantly a pin-sticking pain or ache in the ureter which never left until the stone passed, only it would be apparently lower each time, showing that each attack was gradually pushing it through the ureter.

While at Atlantic City I consulted Dr. Ochsner. He said I had a stone lodged in the ureter and to get some glycerine and take a table spoonful in a glass of water four or five times daily. I did, and with some apparent ease. The pollakiuria was getting worse all the while. I would begin now to have an aching sensation in the penis near the glands. After leaving Atlantic City I attended the dedication of the laboratories of the University of Pennsylvania. All the while having this sticking pain in the ureter. I kept pretty busy attending clinics, among whose was that of Dr. Hoffa of Berlin, demonstrating the three different operations for congenital dislocation of the hip; the bloodless in the very young, the cutting Op. of the bloodless failure and the cutting off the femur heads and tendons of the adductors longi in the grown subject, etc.

I went from there to my former home suffering all the while with this sticking pain. Returning via Baltimore I wished to visit the Hopkins, and it was there I had in the hotel all by myself one of the worst attacks of my life. I tried to get the hotel to summon medical help but they failed, and I was at the mercy of the hypodermic and drank ice water. My room was near the kitchen apparently, as I could smell the gases, and this together with the absorption of urea, morphine, etc., caused nausea and made things move for 24 hours. I was violent from 12 midnight until 3 or 4 in the following morning, finally falling to sleep simply worn out, waking at 7 or 8 next a. m.

I consulted Dr. Hugh H. Young. It seems we all agreed as to the nature. He urged an operation, to make an extra-peritoneal section, but before doing it he sent me to the X-ray specialist. He made two exposures, one over the kidney and one over the ureter, showing negative results. Dr. Young urged me to be operated upon any way, after exploring the bladder with electric light, pronouncing both ureters functioning and no stone in the bladder.

Owing to my having an insurance position to fill I felt I could hardly spare the time to lay up for operation. As I had made almost daily microscopic examination of urine to watch for pus, this also gave me courage with the advice of a friend to wait. I returned home and for thirty days or more I was free from colic and was apparently free from pain aside from the sticking sensation of an apparent stone in the ureter.

I started for a rest and to attend the Academy of Ophthalmology and Oto-Laryngology which met in Denver. I got as far as Wichita and I had an inkling I was in for another siege, and was then lamenting I had passed up the operation. Dr. Basham examined me before I ate lunch and it seemed we were all of one accord as to what was the trouble. At 5 p. m. I proceeded on my journey. I took care to secure a sleeper for the night as I had found it necessary to take opiates, and as they dried up the secretions I had learned by experience and a suggestion from a Philadelphia confrere to inject all the water and as hot as I could bear up the colon, thereby rendering heat near the ureter inside. I also found this procedure answered another good purpose, viz., after you were under the opiate you could retain more water, the reflexes being somewhat deadened. After the pain subsided you could urinate quite freely from the diuretic effect of the colonic flushing. If I passed it out, it served no ill purpose as I would repeat until it did stick.

I had another attack while in Denver and it seemed a car ride would precipitate an attack coming on either during the ride or during the night following.

I took at intervals diuretics of all kinds, but I think the fluid extract of buchu rendered the most efficient good of anything. I drank freely. I kept having the attacks until Sept. 21st, making about a four months siege. I was conscious when the stone fell into the bladder. The ureteral pain subsided. After the stone descended from two to three inches of the bladder the feeling that the stone was in the urethra about one and one half inches from meatus was a constant symptom. After it was in the bladder the desire to void urine was great I being able to hold only from one to two ounces until I would have to void. About four days later I used a glass as was my custom, to watch for this stone in urinating, as I never knew whether I ever passed the first or not. I was called to go hurriedly to an obstetric case and I voided, and just as I had got rightly started I was seized suddenly with a pain as if something like a stone was passing out my rectum and later it appeared in the

urethra. As I was in a hurry and believing the stone had actually passed, I sounded the urethra with a small probe, locating it back of meatus urinarius less than one inch. I delivered it with an ear spoon. I assure you this was a happy moment to me.

The bladder irritability continued up until the following July. The quietude in sitting to hear lectures and work in the Chicago Eye, Ear, Nose and Throat College for three or four weeks seemed to quiet this trouble.

The stone was just like a sand bur and about the size of one. It was not round, but of kidney shape. The little concretions sprang out from the stone proper and were sharp. It was the peculiar shape which made the siege so long, and I think this stone was lodged in the ureter from the first attack four months prior, and when it got in a certain position it would lock the ureter and cause hydronephrosis and the colic would be a necessary evil which always appeared. After each attack there would be slight albumen in urine and microscope showed blood cells, many red and very few white ones.

The kidney functionated all the time except during the colic seizures, but I could always get more relief after the attack by wearing a hot water bottle in front and behind the kidney even when up about my work. This doubtless caused the ureter to relax and expand around the stone. I am of the opinion that the ureter was chronically dilated from the stone to the kidney.

I think some of the reflex symptoms such as pollakiuria, were made worse during intervals of quietude from colic, from a chronic colitis which had existed from an attack of probably typhoid in '91, also complicated by a fissure in ano, which would have been operated upon had not an interne overlooked the matter, during the same anaesthetic when Dr. Senn operated on a metacarpal for what he called tubercular osteomyelitis. Also they were reflexly aggravated by a varicocele.

I thank you. This chain of symptomatology and history might be of some aid in the diagnosing of renal stone and colic.

—O—

Absorption of Corneal Opacities.

Pick (Centralbl. fur. Augenheilk., No. 6. 1907) recommends a 1 per cent solution of ammonium chloride for clearing up corneal opacities when all other remedies, including dionin, have failed to have the desired effect. The method is contra indicated in recent opacities.

MEDICINE AS SHE IS TAUGHT.

By O. P. DAVIS, M. D., Topeka, Kansas.

Medical education has undergone radical changes within recent years. Methods of teaching have been revolutionized. Schools which were formerly independent and exclusively medical have been merged together and fused into federations of units known as "universities." The tendency seems to be to integrate and unify all departments of education into one body with one head. This is supported by authority, for the Germans do these things and any procedure that has the sanction of the Germans cannot be otherwise than the proper thing.

The university, we are told, by centralizing educational methods and concentrating and focalizing resources, can bring forth more thorough and effective work than can be accomplished by several isolated, more or less competitive, and often impecunious schools acting independently. This same argument is being used today in the world of trade in justification of the manufacturing trust or the great department store, viz., that by giving the administrative control to a common head and by commanding the sources of supply with greater formidableness, the output can be improved and its cost reduced to the minimum. But however plausible this argument may appear in theory, it is found specious in application, and much that it promises of superiority and cheapness is never realized in fact. And likewise in the sphere of education the great trusts known as universities, though prolific of promises of advantage, are failing signally at many vital points. The rule of evolution is differentiation and specialization, and the greater the degree of differentiation and the more complete the specialization, the more distinct does the separation of the part become from the whole. The university contradicts by its plan this great law. It presumes to gather up schools of professional and technical learning hitherto distinct and specialized, and to fuse them into a composite and conglomerate whole. In an attempt to modernize it adopts a plan of action that is archaic and primitive. For the federation of schools in a university fashion is a relic of the earliest times when it was necessary from the exigencies of life and civilization for this grouping to obtain and for the aggregation even to be walled in against

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external encroachments. This defensive community of interest as well as the necessity for an easy interchange of the very restricted facilities for instruction afforded a potent justification of the university. But such necessity no longer exists for the retention of technical and professional departments of learning within the confines of academic culture. Schools for general education should have their own preserves, be presided over by those who have special knowledge of their needs, and be content with furnishing well fitted recruits to the special schools beyond their limits. The latter will be all the better for the isolation, and the freedom from the diversions and distractions that so dilute the thoughts of academic grades of students. And they will be all the better for being administered by a management exclusively their own, which can see an urgent need in the clear light of personal knowledge and not through the smoked glass of other needs seemingly more pressing.

I am aware that there may be few who will admit the force of this view, for the university idea is now astride the public mind and is making a loud noise in the public ear. But the galled jade already winces and some day I predict she will cast her load in the ditch where in its exaggerated form it belongs.

A great deal is being said about the benefits that medical education has derived from this absorption of its schools by universities. But many of these alleged benefits are at least questionable. One disadvantage that has most certainly accrued is that medical education is now almost completely presided over and administered by non-medical men. And it is to this fact that much of the distortion and loss of balance in the modern medical curriculum is due. If the prevailing fashion and fad in general education be observed, whether in the grades, high school or college it will be found in the shape of a pedagogic craze for the so called "analytic" method. At the very threshold of the primary school etymology and syntax are taught "inductively;" that is, without chart or compass the child is compelled to laboriously find his bearings and work out a system backwards from effect to cause, whereby to use and understand so common a thing as language. And he is expected to do this at an age when his powers of analysis and induction are not ready for development. In like manner this method is applied to all the fundamental branches, in face of the psychological fact that the mind of the child as well as the mind of the race learns by rote long before it can learn by reason. Faculties of acute observation may be cultivated early in life but the faculties of correlating observations

and interpreting sequences are much later acquisitions of the mind.

As might be expected the exponents of the university idea, when they succeeded in incorporating the medical schools into their educational composite impressed on the medical departments which they came to dominate, this absurd hobby. The medical school came to be a collection of laboratories. Everything had to be studied by the laboratory method with a minimum of theory and of didactic instruction. The laboratory method was even applied to the clinics. The patient became the interesting vehicle of some laboratory experiment and was utilized as such without any proper realization of his essential status as a human being. Such was the effect of this sweeping innovation. And these effects are still in force. The lecture system has become well nigh obsolete. The lines of force that used to emanate from the medical teacher and determined the mental polarity of the student are now discredited as mythical. The laboratory professor and his corps of assistants, often non-medical, all of them, now preside over the student aggregation. The laboratory is the shrine at which the embryo medical mind must pay its devotions. The medical teacher of today, as has already been intimated, is too often a non-medical man. Scientists skilled in the one line over which they preside in the university system, are detailed to impart to the medical student that quota of their subject which the curriculum prescribes. And these men in their various departments dominated by an overweening sense of the importance of their several subjects, are allowed to shape and mould the general trend of medical education. Each tries to outdo his colleague in the number of hours exacted of the student in his particular laboratory. "And combined, they form an oligarchy to which those who would protest against these methods have hitherto been compelled to submit."

The result of such a course is making itself apparent among the newer generation of medical men. Physicians of the new school, as has been pointed out by an eminent essayist, are depending more and more upon technical procedures worked out for them in the laboratory, instead of studying their cases clinically and using their own logical and reasoning faculties to arrive at a sound and unbiased conclusion of their own. They fly to the laboratory for a solution of every problem presented in their practice, thus becoming dependent, neglectful, distrustful of their own observations and undervaluing clinical data. The impression seems to be prevalent "that unless they rest on laboratory confirmation all diagnosis is doubtful, all prognosis uncertain and all therapeutics unscientific."

It is not the purpose of this paper to oppose laboratory methods and research work in their proper place and office, but to insist that these methods should supplement and succeed knowledge otherwise obtained. It is not proper to initiate a student into the mysteries of physiology by a series of vivisections. Nor should pathology be introduced by an exhibit of microscopic sections. Chemistry should be studied from a book, and discussed with the teacher long before the pupil goes into the laboratory. Repetition of trite experiments for the demonstration of accepted and well established truths is waste of time. To put the student into the laboratory at the beginning of his course instead of toward the end of it, is, in my opinion, contrary to the true philosophy of education. He should first know much of the accepted and established doctrines of the science as obtained from lucid texts and from didactic lectures illustrated by proper demonstrations. Then, when corollary experiments are later employed, the work of the laboratory will have a true and corroborative value which it would otherwise lack. Investigation and research must be expected as effects and not as conditions of education. A student can engage in laboratory or research work profitably to himself only after he has been, in a measure, educated for that work. He who thinks education is the discovery of new facts or the rediscovery of old ones does not have a proper conception of the term. Education, in medicine, as in general, consists, not in the acquisition of facts and data of information, but in the training of the mind to assimilate, weigh and apply the truth; in the development of the faculties of thinking, reasoning, and forming sound and unbiased conclusions on any subject under consideration.

Not only has the laboratory idea been carried too far by the exponents of the university idea, but the hospital and dispensary features have been carried to an extreme that is hardly justifiable. Ill advised measures are resorted to to procure "clinical material." Every inducement is offered to the public to pauperize themselves by taking "free treatment" at the dispensary or hospital. A financial consideration is sometimes offered through the press for "interesting cases" at the clinic, and many ingenious methods have been devised for trapping this kind of game. It is not enough that some of the great professors should give free lectures at the medical colleges in order to enlarge their consulting practice, but they must vie with one another in shooting through the chutes at the hospital and dispensary a lot of so-called "cases" in order to get for themselves and their schools eclat. Far be it from my

purpose to disparage clinical instruction. It is essential; but the estimation of its value is not to be based on the quantity of ill-assorted material exhibited. Too much of the hospital and too much of the dispensary leads the student to dissociate disease from humanity and to fix his mind upon abstract morbidity. He sees only disease and not the diseased person. He is overwhelmed and bewildered by the multitude of cases, not patients, that are made rapidly to pass before his eyes.

To accomplish this feat, to furnish this kind of a moving picture show, it is of course necessary that the great medical school should be in a large city. Any little provincial town might furnish a single illustrative case of almost every ordinary disease at least once in a year. But only a city as large as the combined cities at the mouth of the Kaw can furnish the illustrative cases in car load lots, and to such a city shall be the acclaim. A man who kills but one hog a day is only a butcher and his lot is an humble one; but the man who kills 5,000 hogs a day is an aristocrat and moves in the highest society. To what extremities some schools have been driven by this mania for clinical material I need only leave you to imagine. our own state (Kansas) is unfortunate in having no very large city within her borders and only a limited number of gifted teachers, few indeed who have in their mental gizzards the precious pebbles of real knowledge and culture picked up abroad. But she is fortunate in having a city near at hand which bears her name and which is replete with the material and mentality that she lacks, so what matters it if it is fattened on soil that was ever hostile to our domestic interests and harbored a gang of marauders to murder our pioneer fathers and to sack, plunder and burn our early villages, even the ancient seat of our Rock Chalk school. And by way of compensation for ancestral wrongs it is perhaps fitting that the youthful offspring of persecuted sires should take their medicine at the hands of those who once afflicted them.

But however much might be said in justification of a program that drove a proud state to bow down to an imported ideal and a humiliating treaty with hereditary political foes in the name of medical education, there are many who will not agree to the last premise, viz., that a large center of population is essential to a good medical training. There is much that might be said for the small school in the provinces with its less crowded classes, its closer contacts with teachers, its freedom from distractions, its less numerous but more leisurely considered clinics. Perhaps the student will see only an occasional laparotomy. It were enough! For all

laparotomies look alike to the student on the perch. Perhaps he will have to listen to obscure men; men of mediocre talent and opportunities; men who have never basked in the blessed rays of European culture. Yet he may be assured that great qualities of head and heart are not incompatible with obscurity, and that many who are conspicuous for the hour are so by virtue of the little dust of self-praise which they succeed in kicking up about their names.

DISCUSSION

Dr. Sudler:—I have listened to the paper on medical education; and, having been interested in that subject for some time, there are certain points which I would like to take up. With reference to the laboratory method, the essayist seems to think that the laboratory method has been overdone. It is well to remember that all of our advance in the last ten years in medicine has been due absolutely to laboratory methods. The advance in the treatment of diphtheria alone, has demonstrated the worth of the laboratory, and its importance. Unless I am incorrectly informed, the writer of this particular paper, a few years ago, advocated that each physician have his own laboratory in his own office. Again, about separate schools: It is not that the school gains by being connected with a larger institution in so many ways, but principally financially. It needs financial support. The teaching of medicine is an expensive thing. Harvard Medical Department would be just as good a school if it were independent; but the additional power which it receives from financial backing and endowment is what increases its force.

Dr. Hertzler:—I scarcely know which part of the paper the essayist intends that we take seriously. In the beginning he sets up the German schools as ideal; and, in the end, he ridicules them. The chief advantage in the German University is the money, as Dr. Sudler says. Personally, I have taught medicine all the way from Freshman to Senior, and I think I may speak with authority. There is nothing interests the student so much as laboratory work. The amount of didactic work can be reduced to the minimum, but the laboratory work is of vast importance. As to the value of large clinics, that depends upon the extent to which one applies the term. Even in a city of this size, it is difficult, almost impossible, to furnish the students the clinical material which they should have. Most of the people are disposed to fight the publicity which the clinic brings, so it is absolutely impossible to bring the pupil into touch with many of these cases.

Dr. Halderman:—I cannot understand why the gentleman should attack the present system of university education and laboratory methods and everything else for the advancement of scientific medicine, simply to win a point against the medical department of the University of Kansas.

Dr. Hamilton:—I have listened to this paper. Every time that I get up to speak it seems that I have to oppose. I cannot but speak upon it differently from the gentleman who wrote the paper. I think the University idea is the main thing which has brought about the impulse to

higher education in medical colleges. If you look back and see the time when medical colleges were separate, you will recognize this fact, I am sure. I have seen the time a few years ago when men were graduated from the medical colleges who had never seen an English grammar. It is only now, when they are connected with the University, that these things are demanded. If it were not for that, we would have a great many ignorant physicians; and, an ignorant physician is a dangerous thing. As to the laboratory method: Even if he be shown by the laboratory method before he knows anything of the subject, if he has had no lectures, he sees the thing as it is. That he will not forget. When he hears of it in the didactic lectures, or sees it in reality in the clinics, he knows what he is seeing—he has the picture of it.

Dr. Kasey:—I am not going to say how medicine is taught or ought to be taught. If we were to take as our criterion the article that recently appeared in many of the secular papers as a quotation from the proceedings of the council on medical education of the A. M. A., it would seem that there are very few of us who know anything about it. I wish to read the first paragraph of it: "There are on an average 4,000 doctors graduated every year by the medical colleges of the country and about three fourths of these are utterly incompetent and should never be permitted to practice medicine. The average medical college is lacking in proper equipment, the instructors are wanting in the necessary ability for their task, and their examination methods are useless." It seems to me that things should not appear in the secular press. It gives the laity the wrong impression of medical colleges and medical men. It is not a very good way of educating the laity. It is all right that such things should appear in the medical press, but I do not think that they do the physicians as a class any good to appear in the daily press.

Dr. Johnson:—It seems to me that the medical profession would be elevated greatly by cutting out about three out of four of the little medical schools situated in the state. We have at the present time two or three in Kansas. We had several in Dallas. They started with one in Texas, and now have seven, I think. I was connected with one for three years' time; and, in all the three years lectured, I think we never turned out a student that had any business to practice medicine. They are cutting it down now. The profession is getting into a place where they can do a little teaching. Heretofore it has been done with an idea of glory. Now, I do not say that they are all organized for this reason. One school is started with a noble purpose of education; then another starts; one or the other or both get jealous and they work against one another in competition. I believe that there should not be more than one school allowed in each state. That should be on a University basis; and, the lecturers should be remunerated. They cannot afford to do otherwise. Frequently it occurs that a doctor cannot afford to leave his practice; the students cool their heels at the desks; and, their time is wasted. Every man should receive something for the work that he does here. The school should be endowed; the professors or instructors salaried; and do away with a lot of these dinky little medical schools that have no laboratories and cannot teach.

Dr. Shaw:—I cannot agree with the gentleman who has just left the floor. It seems to me that if I had taught in a medical school three or four

years and had not turned out a single man who was competent to practice medicine, I should have resigned my position. The trouble does not all lie in the medical schools; it lies largely in the men. Abraham Lincoln could maul rails and yet be president of these United States. It has been said that you may give a man a good education; and, he may have plenty of experience; and yet, he cannot teach school. A man may be a graduate of some of our great universities in medicine and yet lack the essential principles of a good practitioner; and a good practitioner is what we should all like to be. I am in favor of every advance along our lines that would bring out better work, and produce better men. I am in favor of University education; but, Gentlemen, I would rather see one single case as it came to a clinic, see it every day, watch it from the start to the finish, understand it thoroughly; than to have patients pass before me in great numbers and not be able to know what pathological condition exists in any. I was in a New York medical school for three weeks for clinical work. They had too many clinics. You cannot get to it and have thorough examination in any case. There are some points of advantage which the small school has over a large school. Your didactic work can be just as good in a small school. Your clinical work is not apt to be as good; your pathological work is not as good. That is where the financial backing of a large school has the advantage. But, as a rule, in a small school the students can get into touch with the teachers, which is a decided advantage to the small school. I am an old teacher myself in the public school and I know what teaching is. It takes training to be a teacher. Every clod-hopper that comes into a medical school cannot be a teacher. Teachers are born, not made. Just a few years ago, one of our men was going through our college in Manhattan. He was trying to illustrate mechanics. A man who was in the blacksmithing department asked what was cast iron and what was steel. What business did he have in the blacksmithing department? Some one asked his value—what was he worth to the school? The reply was made that he was one of the finest musicians that the school contained. Let him study music.

Dr. Light:—I wish I were gifted with the flow of oratory that some of you people have. We must use common sense. This is a common sense question; and we must so consider it. Now, I graduated once upon a time and I do not know whether I was fit to be graduated or not. I do know that if I had not been endowed with an industrious mind, I should not have been ready yet. I have known many men who were not fit to practice. They ought not to be allowed to do it; but they are doing it today. We ought to recognize the work the American Medical Association is doing to cut down the number of schools. We also ought to cut down the graduates. The idea that we can turn out all these men and have them make a success in practice is ridiculous. We ought to have more strictness in this thing. When a man graduates he should be more broadly educated than he is.

Dr. Walker:—I did not hear all this paper; but from the discussion, I can judge very well. Now, I have not any fuss with the University school, but I do not want to condemn the other form. I had the University training and in the Kansas State School, and I am not going to "knock" on the school. I helped organize the first anatomy class that was ever organized in the University of Kansas. We petitioned the faculty to let us

have a cadaver. Two or three of the members of the faculty thought that we ought to be suspended because we had the temerity to ask for a human subject. They thought we should have been content with dogs and cats. I have also had experience in teaching in the other form of school; and, I want to say that I do not believe that it is best for either to condemn the other. I believe that we lose some things in the University schools that we have in the other schools. I do not believe that we have men teaching medicine to-day such as Gross and Flynt. Of course, we have large clinics which are carried on by surgeons of ability; but the main teaching of medicine is left to the newly graduated. I believe that the contact of the medical student with his professor of large experience in practice amounts to a great deal. You take the smaller schools and let each student have a personal acquaintance with his teacher; and not only that, but he comes in contact with him in his office practice; and he gets an inspiration that cannot be gotten in the larger school. I am glad to see the increase in the preliminary education. I would not like to say that in my teaching I never saw one who was fit to graduate, but we had many. I know, however, that we had lots and lots of men who were always changing schools; and when they were admitted into another school, they were admitted into an advanced class. I do not believe that it is the province of either school to condemn the other. I think that there is room for both of them. There are too many medical colleges, perhaps, but they are very rapidly being eliminated. It is not so much the quantity that is objectionable, however, as the quality. I repeat: I do not believe it is a good thing on the part of either to condemn the other.

Dr. Bolton:—I agree to a large extent with the last speaker on the floor. There are two sides to this question. You have had both sides presented to you to some extent. Now, if a University man is a man who wants to be unreasonable and unfair, he will talk University, University, University; and the man on the other side will do the other thing. There are good points to each, however. In the University plan, the man is absolutely free. He is not depending on the tuition from the students personally, and he can devote more time to his students if he will. The University also has a fund for its support. Fortunately or unfortunately, I happen to be a graduate of a small school; and I want to say that the points brought out in its favor are good. There is no one but who will admit that a class of 25 can do better than a class of 500. If we were to limit our medical colleges to the University, all men would have to go to the University who are seeking a medical education. What is the result? You have a class of five, six, seven hundred or one thousand students. I believe that doctors are born as well as teachers, and just as the gentleman says, one need not think because a man has mauled rails, or comes from the farm, he will not make a good doctor. A man does not have to have a college education to make a good physician. If it is not in the man, you cannot get it out of him. I want to give you an illustration: You have many of you heard Dr. Wyman of St. Joseph talk; and you know that he is an extremely brilliant man—a wonderful man from a teacher's standpoint, but he could not practice medicine. He tried, and failed. That brings out the point that some men will make good teachers but they will not make good practitioners. I do not believe that it is right, reasonable, or

fair that we should cut out the small colleges. There are some schools who send out people to plug for them. They do such things as this. Such schools should be cut out. I do not think when they do things like this that they should be allowed to exist—they should be cut out

A motion was placed before the house for the closing of discussion, which carried.

Dr. Davis:—I feel better. The paper or whatever there was that belonged to the paper has called out a fine discussion. I notice that papers rarely happen to be given the distinction of having their discussions cut off by a vote. I have a few words to say in closing. I am very sorry that I should have been misunderstood and be made to stand for something that I would rather not stand for. I am not against research in medicine. I am not against the laboratory in medicine. I am not against the university. I am proud to state that I am an alumnus of the Kansas University. What I said that had any reference to the University was largely in a jocular manner. At the same time, I do insist that the laboratory method in teaching has been carried to an extreme that is not justified by the results obtained. At one time, medicine was taught by the preceptor almost exclusively. Medicine was learned as an art from the hands of an eminent preceptor—by his individual instruction, by his personal contact with the pupil, by leading him by the hand, so to speak. And who will say that there were not many distinguished disciples of the art in those days? And then the laboratory entered into medicine. Those who had practiced and studied medicine as an art, began to study it as a science. From this beginning, the excess in the laboratory method has come about. Research work and medical teaching are not necessarily intimately connected. The research man is not necessarily a good teacher. In fact, he is quite the opposite, as a rule. We want to educate our men for the practice of medicine and they should be taught to develop their reasoning powers, their deductive powers; and I hold that the educational value of the laboratory is not what it ought to be. It should be a sequel to medical teaching and not an instrument to medical teaching. Referring to Dr. Sudler's remark relative to my use of a laboratory: I did once read a paper advocating the use of the laboratory for the general practitioner. I use laboratory myself; but, that does not contradict the sayings of my paper.

—O—

Blindness from an Immense Dose of Quinine.

Dr. H. W. Woodruff (Chicago Ophthal. Soc., March 11th) exhibited a patient who thirteen months ago had been given 915 grains of quinine in four days. Total blindness of sudden onset lasted four days, then vision returned gradually, and is now 20-60 and 20-40, although there is a marked atrophy of the nerve heads, with typical concentric contraction of the fields.

ABORTION.

By H. H. BROOKHART, M. D., Scammon, Kansas.

Abortion, the premature casting off of the products of conception before the end of the fourth month, as generally given, but practically, we might as well make it the sixth.

In taking up this subject I am aware it is one of the most, if not the most, vexing questions we have to deal with. Therefore it behooves us to be well prepared to meet it. But, before speaking of causes and treatment, it will be necessary to grossly consider the anatomy and physiology of the uterus and ovule. The uterus is the most extraordinary part of the female economy. It normally has three distinct products. From birth to puberty, it is undeveloped and unimportant. From puberty to menopause, about the age of fifty, it is very active, and has a marked influence on the whole being of the woman. From that age on, it sinks into insignificance. During its active stage it is the normal lodging place of the impregnated ova. When this impregnated ovum becomes fixed within this active uterus we have conception, and instantaneously a communication is set up through the nervous system, and the whole economy of the woman begins to change. After conception takes place the mucous membrane of the uterus becomes thickened, forming the decidua vera, and at the point of attachment of ova the membrane goes on growing until it completely envelopes the ovum, and is here known as the decidua reflexa. In a little while the allantois is developed, and from the foetal body two distinct membranes are formed, the amnion and chorion. The chorion attaches itself to the uterus by little rootlets, which extend into the uterine gland. The amnion is only a membrane which secretes the liquid amni. The foetal ball is now everywhere attached to the uterine wall, and receives its nutrition by endosmosis from the mother's blood, and is nourished in this way until the end of the second month when the placenta begins to form. Then the chorion loses its tufts, except at one point, where it becomes excessively vascular and increases its thickness, and here with the thickened decidua forms the placenta. Up until two and one half months there is no placenta, as far as abortion is concerned, but from this time on it is the all-important.

Read at the forty-first annual meeting of the Kansas State Medical Society, May, 1907, Kansas City, Kan.

The causes of abortion are many. Maternal causes are nervous disorders, reflex influences and drugs. Some women are so nervous that any sudden fright will cause them to abort. Not more than a few months ago, I treated a lady, Mrs. R—, who after a fright aborted, and under the placenta was a blood clot which acted as an irritant causing contraction and expulsion of uterine contents. This clot was undoubtedly formed at time of fright, as she felt the contraction of the uterus at that time. Chorea and tetanus are frequent causes. Appendicitis is a much more common cause than given credit for. I have treated two patients, one has aborted twice, and the other three times within a year, and I have been unable to find a cause other than a chronic catharal appendicitis. The abuses of drugs, such as ergot, cotton root, tansey, pennyroyal, and others, will in some produce abortion, while many a woman could take as much as a toxic dose of these without any effect in emptying the uterus. The toxemia of kidney insufficiency, also the toxemia of poisonous gases, chief among them carbonic acid gas, and high temperatures during the different fevers, are common causes. Local causes include all acute and chronic pelvic disorders, as retro-displacement, metritis, endo-metritis, salpingitis, tumors and malignant diseases. Tramatisms, as a blow, fall, and jumping, as from a high buggy, etc., are frequent causes.

The causes within the ovum are any that may cause its death, as syphilis, low position of the placenta, torsion of the cord, etc.

PRODUCED ABORTION:—In this country the criminally produced, whether it be by the criminal abortifonee, or the woman herself having in a crude way been taught the use of a sound, whether it be a hat pin or baling wire, has become appalling. I had the experience of treating a case some two years ago in which a baling wire had been used unsuccessfully, but she had succeeded in punching several holes in the uterus, causing the death of the oetus, which had partly mascerated when first seen; yet the uterus refused to expel its contents,. So we see the extreme damage that may be done, and yet abortion not be produced.

When is a physician justified in producing abortion, or is it his duty to do so? I think it most certainly is his duty, under certain conditions. When the life or intellect of the woman is in serious danger, as in uncontrollable vomiting, for it is a fact that a great many women die each year from this cause. In a great many cases pueripial nephritis is absolutely criminal not to empty the uterus. In grave cases of cardiac disease, it is very dangerous to let a woman proceed far into gestation. In rare cases of chorea and when

the pelvic diameters are so very contracted as to make delivery at full term impossible. In placenta previa, recognized early, I think it is the best thing to do, for the per cent of children saved is so small, and a mother's loss so great, it is not worth the risk to let her proceed with gestation, unless it be under the best of hospital advantages. The per cent of abortions to labor at full term is hard to determine. In my experience it has been about one to three and one-half. When the accident of abortion occurs one of several things may occur. In the early stages the embryo intact may be expelled, the decidua vera, and reflexa, the amnion and chorion, and foetus, or the foetus, amnion and chorion, the decidua being left. This is when we are liable to err, especially if this had happened before our arrival, and we are informed that all had passed. Take no one's word for it, and treat her with doubt, or after the formation of the placenta, we may have it adhered partially or in whole, the foetus being expelled.

TREATMENT:—To thoroughly empty the uterus, how best to do this? It varies in different cases. In a very small per cent of cases the entire contents are expelled by the contractions of the uterus, and requires no special treatment, except it be in a very nervous patient, where the pains are very irritating and accomplishing little, and hemorrhage is profuse, when a hyperdermic of morphine and a tampon serves us well. After the foetus has passed and the decidua or placenta, as the case may be, does not pass within a few hours, the wise thing to do is to use a curett, using a spiral or dull wire curett. If this cannot be accomplished without an anesthetic, I find an ideal in Abbott's Alkaloidal Hyescine Compound.

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The Prevention of Blindness.

Lucien Howe (J. A. M. A) makes a plea for new methods in the prevention of blindness. He shows that ophthalmia of infants is the most important cause of blindness; and how much it costs the state of New York and the United States to care for these unfortunates. He urges obstetricians to experiment with various compounds of silver in large series of cases at large hospitals, to decide the best prophylactic drug.

The cessation of severe pain^d during the course of acute appendicitis often means perforation.—American Journal of Surgery

Good Work.

Illinois Medical Journal.

The Council of the Chicago Medical Society, at its regular meeting in June, endorsed the work of the Public Health Defense League, the national headquarters of which are in the Unity Charity Building at New York City.

The league has four directors, some of the most prominent business and professional men in the country.

Its objects are as follows:

1. To combat all forms of quackery and charlatanism.
2. To prevent food adulteration and drug substitution.
3. To prevent the sale of narcotics and alcohol disguised as patent medicine.
4. To prevent the circulation of indecent medical advertisements.
5. To advocate the establishment of a National Department of Health.
6. To carry on an educational campaign for the spreading of accurate knowledge concerning the public health and inculcating of higher health ideals.
7. To protect the public health by assisting the constituted authorities in the enforcement of existing laws and by urging the enactment of uniform legislation in all of the states on matters relating thereto.
8. To co-operate with other societies interested in any public health problem, and ultimately to effect a plan of union or co-operation of all organizations interested in the public health.

Ophthalmia Neonatorum.

Herf (Munch. med. Woch., No. 20, 1906) recommends "Sophol" as a prophylactic in ophthalmia neonatorum, claiming it to be equal to silver nitrate and protargol, and less irritating than either. From 5 per cent to 10 per cent solutions are used.

Everything is to be gained and nothing to be lost by having patients remove enough of their clothing to allow of a completely satisfactory examination in all cases. Instances can be called to mind by any physician of erroneous judgments arrived at before exposure of other parts of the body showed conditions altering one's opinion. Especially is it important to compare the corresponding members of the body on the sound and the affected side in all doubtful cases.—American Journal of Surgery.

THE JOURNAL OF THE KANSAS MEDICAL SOCIETY.

Entered at the Postoffice at Columbus Kansas, as Second Class Matter.

CHAS. S. HUFFMAN, EDITOR

J. E. SAWTELL, }
GEO. H. HOXIE, } ASSOCIATE EDITORS

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Seventeenth Annual Meeting of the Association of American Medical Colleges.

This meeting of the association, which has been most influential in raising and standardizing the curricula of the medical colleges of the United States, was notable because it was attended by delegates from the stronger Eastern schools which ordinarily hold aloof from its discussions. Dr. Lindsay of Topeka, and Prof. McClung of Lawrence, were the two Kansans in attendance. The association decided to give no time credit to holders of a bachelor's degree, but it permits medical schools to grant subject credit on satisfactory examination. In all cases four years of actual residence at the medical college must be required. Each medical college in good membership must hereafter print in every annual catalogue a table of the total number of hours work given at the college, arranged both by subjects and years. We fail to find this provision met by the Kansas Medical College, the University Medical College of Kansas; but it has been met by the Clinical Department of the University of Kansas in its recent announcement. In this connection we cannot forbear mentioning the laughable array of work and clinical facilities paraded by the University Medical College of Kansas City. It names every hospital in the city—whereas as a matter of fact it has no regular clinics in any except its own and the city hospital. But to resume, the Association dropped from membership the College of Physicians and Surgeons of Boston. The College of Physicians and Surgeons of St. Louis withdrew under fire. The State College of Physicians and Surgeons of Indianapolis (University of Indiana), Vanderbilt University of Nashville, Cooper College of San Francisco were elected to membership. The application of the Ensworth Central Medical College of St. Joseph, Mo., was rejected because of its failure to do high grade work in the first two years. In the election of officers, Kansas was honored by the election of Dr. Hoxie of our State University, as one of the vice presidents.

An Unfortunate Condition. The welfare of the profession of medi-

cine in Kansas depends more on the Board of Medical Examination and Registration, than upon the Board of Health, or any other one political factor. The last legislature gave the Board of Health \$2,500 a year for a permanent secretary, while the Board of Examination has nothing. In order to get their work done, the members of the latter Board take terms in acting as secretary. This of course is very disadvantageous because just about the time a member learns his duties as secretary, some one else is elected. In this respect then the work of the Board is seriously crippled. It has no permanent office. A tremendous scandal arose at the last examination because the question papers were stolen from the state printer and peddled out among the candidates. Hence, because of the alleged laxity of its methods the Missouri Board has broken off reciprocity relations with Kansas. Thus both at home and abroad our licensing affairs are in disrepute. One of two things should be done: Either we should abolish the Board of Examination and give its work to the Board of Health, or we should put the Board in position to employ a competent secretary to do its work. Governor Hoch advocated the former two years ago; but his political friends believed the move a bad one and he dropped it. It is now up to the Kansas Medical Society to do something. The timidity shown by our committee on legislation is only equalled by its failure to develop some definite plans for bettering the status of physicians in Kansas. We hope the present committee will use a little more energy in ascertaining what should be done and then in uniting our forces to support its plans. This means self sacrifice—but if our committeemen are not willing to sacrifice some time and money, then they should resign. The Kansas Medical Society is no longer a mutual admiration society of a few men well fixed and comfortable, but an organization of the rank and file to better the condition of things medical through out our borders.

G. H. H.

Much is being said and written relative to the advertising that physicians get in newspapers by having reports of operations and cases written up. In many instances where a newspaper publishes an article, descriptive of an operation or a case, the doctor mentioned may have had no knowledge before hand that it would be printed; but the enterprising reporter, in his zeal to get news for his paper, will eagerly send in news of this kind to his paper. In some places, we know that reporters make daily or weekly visits to the doctors' offices in search of news of this kind, and often the

printed news of this character is obtained from the friends and relatives of the patient.

The Journal receives many newspaper clippings, of which the following is a sample:

"Miss C. A. had her tonsils amputated by Dr B. Tuesday. The doctor did the job quickly and almost without pain."

The physician who sent the above clipping, wanted to know if it was ethical (?) advertising, and if within the proper limits; remarking if it was he "would like to take advantage of a similar write up." It is our opinion that it is not ethical, and on the other hand we do not wish to be understood as saying that a physician's name should never appear in print in connection with a case he is treating or an operation performed, but such newspaper mention should never exploit any particular operation or detail the treatment of any particular case. The conscientious physician or surgeon does not want to see his name in print, in connection with some case or operation, but wants the results of his work to speak for him, as to his skill in surgery or treatment of disease. C H.S.

Dr. Milton T. Evans sends in an encouraging report from Chautauqua County. With only about fifteen doctors in active practice in that county, they are maintaining a most excellent society. They succeeded in getting nearly every doctor in the county to join. This is due in a large measure to the energy and enthusiasm of the secretary, Dr. Evans.

Chautauqua county Medical Society was only organized February last. Since that time they had five meetings, and every one a success. This county was one of the last to be organized in the state, but is proving to be one of the most useful. The officers and members are to be congratulated on the interest manifested in pushing forward the work of organizing the medical profession. C.H.S.

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NOTE.

Secretaries of the County societies are earnestly requested to send reports of meetings and all items of personal mention and of local or general interest for publication addressed to Editor, Columbus, Kans.

WHO MANUFACTURES THE NOSTRUMS AND PATENT MEDICINES? IN OTHER WORDS, WHO MAKES DOPE FOR QUACKERY?

Editorial American Journal of Clinical Medicine.

Some time ago we aroused quite a furore in certain quarters and the echo is still reverberating throughout the country—by asking the following question: “Who manufactures the patent medicines and quack nostrums? In other words, who furnishes quackery with the dope?” This question was justified by the fact which is well known in pharmaceutical circles, that the vast majority of the preparations with which the laity is being pestered and poisoned so energetically and so persistently are not as a rule made by the people who are the real owners and promoters. Practically all the proprietors of the fake patent medicines have not the slightest idea of chemistry and manufacturing pharmacy and it would be as impossible for them to make an elegant pill or tablet, to fill a soft capsule, or to make a palatable, compatible mixture as it would be to solve a problem in differential calculus or astronomy.

At the meeting of the A. M. A. at Boston, Dr. Kebler of Washington, Chief of the Drug Laboratory, Bureau of Chemistry U. S. Dept. of Agriculture, showed that a very large proportion of the nostrum manufacturers, 95 per cent. perhaps, have no laboratories of their own, but their remedies are made in the laboratories of the great and supposedly ethical pharmaceutical houses, which are soliciting the business of the doctor, a business which these houses are at the same time secretly undermining. They say it is “business,” we say it isn’t fair. It is a direct incitement to quackery, for we have no doubt that many of those quacks would not go into business at all if they had to construct their own formulas, build their own laboratories, employ chemists, etc. It would be too troublesome and too risky, while the great so-called ethical houses make it very easy and smooth sailing for them. All the quack has to do is say for what ailment he wants that particular nostrum to be, and the great houses put their knowledge, experience and facilities at the quack’s disposal. They construct his formulas, make the preparations, label them artistically and attractively. In short, everything is done to make quackery attractive, and all the nostrum proprietor has to do is to pay the bill and then to push his dope on to the credulous people.

As a contribution to the discussion of the secret-nostrum question and as essential to its solution, this question must be answered. Justice can be done in no other way than by telling all the truth.

It is incumbent upon the Council of Pharmacy and Chemistry and the Journal of the A. M. A. to possess themselves of these facts in their entirety and to let in the light. The inquiries are becoming more and more insistent and already official action has been taken. For instance, the Section of Pharmacology and Therapeutics at the Boston meeting, passed a resolution which read in part as follows:

"The section learns with regret that certain manufacturing pharmacists have practically placed the facilities of their plants at the disposal of venders of some of the worst and vilest nostrums by which the people of the United States have been defrauded. It is obvious that such practices cannot be too severely condemned, especially if the patronage and confidence of the medical profession is to be retained."

The Kansas State Medical Society has also positioned itself, for at its annual meeting in May the following resolution was passed: "Resolved, That manufacturing pharmacists who have engaged in whatever extent in the making of nostrums are hereby requested to abandon such manufacture, either directly for their own trade, or for exploitation by others."

It is up to the doctor to probe farther in this matter. Who is it that is making "cascarets," for instance, or "Carter's pills," "Stuart's dyspepsia tablets," "Damiana wafers," "Force of life" remedies, and a score of other things sold directly to the laity? Do you propose to remain in partnership with the men who make the "patents" and "nostrums?" Do you approve of a business policy that preaches and lobbies for "ethical" preparations with the doctor, while it "borrows" the formulas of men who really originate successful proprietaries, supplies the druggists with ready made mixtures for counter prescribing, and solicits (on the q. t.) the immensely lucrative business of men who are selling train load after train load of habit forming "dope" to the laity—to their harm and your business injury?

These are questions which it is worth your while to consider and by the solution of which it is worth your while to be governed in the conduct of your own business.

We have no desire in any degree to tear down any honest business structure; we would impede the progress of no conscientious man; but we can no longer keep silence on this subject which is of so great importance to the medical profession—that which is the very backbone of quackery and fraud—that which renders their bombastic and soul-and-body-wrecking methods possible.

Let us assume that it is pure thoughtlessness—that when the

matter is brought to their attention they will stop, but let us keep a weather eye on them to see that they do it, stop and stay stopped, that years of honesty and loyalty to the profession may at least attenuate the injury and disgrace they have caused to the profession.

THE ATLANTIC CITY MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

Illinois Medical Journal.

The 1907 meeting of the American Medical Association, held at the queen of Atlantic coast resorts, Atlantic City, while not so largely attended as the meeting held in Boston, was of unusual interest by reason of the important matters brought before the Association. A determined effort seems to have been made to make trouble by gentlemen representing the proprietary medical interests, the so-called independent journal interests and the usual quota of objectors found in every organization. But the verdict, as might have been expected, resulted in a complete vindication of the officers in charge of the Association for the past ten years, during which time it has shown such remarkable growth and has accomplished so many valuable reforms. One great objection urged against the officers of the Association was the publication of the American Medical Directory, but, as far as our experience goes, there has been no one thing undertaken by this organization which has been so universally applauded as this publication, unless it should be the exposure of the absurd claims of the proprietary medical interests. Both these movements were endorsed.

The subject of medical education was presented by the committee, of which Dr. A. D. Beven of Chicago, is the chairman, and was said to be one of the most interesting features of the meeting. A large proportion of the night medical schools (three out of four) were found by this committee to be in Chicago, and, as all were condemned, it stands to reason that a great deal of the reformatory work in medical education devolves upon the profession in this state. The Association endorsed the recommendations of this committee and it is probable that a foundation was laid which will lead to practical results in the near future. Some of the startling statements made by this committee were:

Of the 160 schools, only about 50 per cent. are sufficiently well equipped to teach modern medicine. About 20 per cent. have no claims to recognition whatever.

Many of the poor schools are conducted as quiz classes for the

purpose of preparing the student to pass the state examination, and not with the object of making him a competent practitioner.

Modern medicine requires a better order of intellect than that possessed by the average student entering its ranks today in this country.

In this country of great wealth and great population and of high average intelligence, we can no longer be satisfied with our present standards of medical education, nor should we be satisfied with any except the highest and best.

Medical schools need endowments in order to meet the demands of present day medicine.

If the public realized the enormous difference that exists between well trained, modern medical service and ignorant, inefficient medical service, they would soon demand and obtain the needed reforms.

A state without the protection of good medical laws, well enforced, becomes the dumping ground of the low grade medical school, with its output of illy perpared medical men.

The next meeting of the Association will be of especial interest to the practitioners of Illinois and the Mississippi Valley, as it is to be held in Chicago. By the time of the meeting there will be from 35,000 to 40,000 members and the circulation of the Journal will have reached the 60,000 mark. Already the Journal has become the largest and most widely circulated weekly in the world. The attendance at the next meeting should be a record breaker, and the membership of our State Society should be greatly increased by this meeting.

THE PHYSICIAN AND THE PUBLIC.

Major Pilcher, Editor Military Surgeon.

While stationed in the far West some years ago my attention was attracted by the unusual ability of a young soldier who had come under my command. Believing that higher things might be in store for him than that of an enlisted man of the army, I began instructing him in the art of medicine. He became much interested in the subject, and, under my direction, pursued the work until he acquired the degree of doctor of medicine and ultimately became employed as an assistant in the Army Medical Museum at Washington. When the entrance of our army into Cuba made the conquest of yellow fever one of the most important forces to be accomplished, he and his chief, the late lamented Walter Reed, determined to enter upon a series of investigations in that direction. The proper ex-

ecution of the work demanded animal experimentation of the highest type. No creature of a lower grade would be sufficient. Humanity itself must be the subject. In the grandeur of self sacrifice, this glorious fellow submitted himself to the bite of a *stegomyia calopus* from the sick room of a yellow fever patient. The disease promptly developed in its most severe form. The high temperature, the saffron hued skin and the black vomit followed in rapid succession. Death reached out his fleshless fingers for his victim—he tottered upon the very brink of eternity—and only the devoted care of the ablest physicians, based upon a constitution strengthened by correct living and good habits, saved him from the fell destroyer.

From this experiment grew that wonderful series of studies upon which has been based the true theory of the control of yellow fever. I refer to this particular case because I am prouder that I can state that the result of my own teachings brought into the profession a man so highly typical of the best in practice and experimentation. That his example was followed by Jesse Lazear, in whom the experiment resulted fatally and whose brilliant young life was sacrificed for the benefit of the people of tropical America, is but an additional demonstration of the great danger which this loyal physician incurred, without hope of reward, for the benefit of the human race.

This instance reminds me of the case of Guido Chauliac, the great French physician of the twelfth century, whose bold campaign against the plague, which ravaged the continent of Europe, won for him an experience similar to that of our young American medical officer—he acquiring the disease and barely recovering therefrom with his life. But Guido Chauliac was munificently rewarded for the service, was commissioned as a surgeon to the papal court, and honored with place and pelf by successive pontiffs.

What a contrast between the attitude of the twelfth century and that of the twentieth. See Guido rich and powerful; then turn your eye to the twentieth century and observe James Carroll, the hero of the extinction of yellow fever, a simple lieutenant (promoted to major by special act of congress since the delivery of this address) in the United States Army, toiling and working from day to day for his living and for the support of his little family, while altogether unworthy politicians are swimming in the seas of governmental profit and swaying extensive powers. This is a most apt illustration of the rewards for which the young medical man of today has to look in his work.

To no profession does the virtue of charity appeal to so large an extent as that of medicine. The amount of free medical service rendered by physicians is greater by far than the amount for which they receive payment. Many a physician does work without charge which would treble and quadruple his income were he to receive proper compensation for his services.

What other occupation devotes its greatest efforts to reducing the demands for its exercise? Can you imagine a shoemaker entering on a crusade to discourage the wearing of footgear? Can you conceive of a builder devoting his life to the advocacy of open air living? Or is it within the limits of belief that a great meat packer should found an institution for the furtherance of vegetarianism?

Nevertheless, the chief duty of the physician, as is fully recognized in the profession, lies along the very lines which we have indicated. It is his duty to cut out from under himself the very means of his support. He owes to the public, not so much the cure of individual cases which may arise, but the elimination of the great causes of those affections. It is not so much his work to administer the remedies which may cause the recovery of a single patient from illness, as it is his higher duty to discover the cause of disease and to eliminate them from the life history of mankind.

MEMBRANOUS CROUP.

By V. E. Lawrence, M. D., Ottawa, Canada, in *The Canadian Journal of Medicine and Surgery*.

Of the many calls which come to the general practitioner, few, perhaps none, are more urgent or more dreaded than those to attend a case of croup.

Croup is so swift and fatal in its action, and the anxiety and dread with which it is regarded by the child's parents is so intense, that the doctor is impelled to use his best efforts to allay the attack.

Some years ago, dissatisfied with the results of the ordinary treatment for croup, I was led to try the Brown Iodide of Lime, and the results were so markedly successful that Membranous Croup has had no terrors for me. In the last seven years I have treated over twenty-five cases of this fatal disorder with Iodide of Lime without a single failure. Under its use the symptoms quickly improve and invariably disappear, and the patient moves forward to a sure and rapid recovery.

My experience with Iodide of Lime has convinced me that it is a true specific for Membranous Croup, and that its properties war-

rant the most careful attention and widespread use on the part of all physicians who are called upon to treat this disease.

One reason why it has not become more generally known and used, is that it is not ordinarily mentioned in works on therapeutics; and another, and perhaps more important one, is that it is confused with the ordinary Calcium Iodide (yellow) which is practically inert. The Brown Iodide of Lime is entirely distinct from Calcium Iodide, and is infinitely more active and potent in its properties.

In all cases of croup, however, it is necessary to distinguish carefully between membranous and diphtheritic. Some cases of diphtheritic croup, where the exudate confines itself to the trachea and smaller tubes and fails to appear on the tonsils, resemble membranous so closely that a definite diagnosis is difficult, if not impossible; but these cases are rare. and the tonsils become affected not later than the fourth day. Again, the exudate of membranous croup is fibrous and elastic, while that of diphtheritic croup is non-elastic and cellular. Even in diphtheritic croup, however, the Iodide of Lime assists in removing the exudate from the trachea, so that it is indicated whenever croupous symptoms appear. Besides, it is not poisonous.

The same properties which make it a specific in croup make it valuable in all cases of enlarged glands, including fibroid tumors, prostatitis, etc. I prescribe 10 to 15 grains in four ounces of water. Dose, teaspoonful every fifteen to thirty minutes until symptoms improve; then less frequently. The deposit of lime in the bottom of the cup may be allowed to remain unshaken, as the virtues of the remedy are in solution. It must be protected from the light.

In closing, I cannot express too strongly my faith in the Brown Iodide of Lime, and I urge those of any fellow physician who are unfamiliar with the preparation to try it and see for themselves its valuable properties.

Hettinger Bros.' Mfg. Co. of Kansas City, Mo., carries one of the most complete and up to date line of surgical instruments of any house west of the Mississippi River. This reliable house is ready to furnish anything in the way of surgical supplies that a physician or surgeon may need.

The state of Georgia has decided that Dr. Crawford Long, who did pioneer work in anesthesia, shall be one of the two citizens who shall be commemorated by a statue in the capitol at Washington.

THE DOCTOR.

The following poem was written by James Whitcomb Riley in memorium of Dr. W. B. Fletcher of Indianapolis who died April 25, and was published in the Indianapolis Morning Star on the day of the funeral:

THE DOCTOR.

“He took the suffering human race;
 He read each wound—each weakness clear—
 And struck his finger on the place
 And said, ‘Thouallest here—and here.’ ”
 —Matthew Arnold.

We may idealize the chief of men—
 Idealize the humblest citizen—
 Idealize the ruler in his chair—
 The poor man, or the poorer millionaire;
 Idealize the soldier—sailor—or
 The simplest man of peace—at war with war;—
 The hero of the sword of life-and-drum . . .
 Why not idealize the Doctor some?

The Doctor is, by principle we know,
 Opposed to sentiment; he veils all show
 Of feeling, and is proudest when he hides
 The sympathy which natively abides
 Within the stoic precincts of a soul
 Which owns strict duty as its first control,
 And so must guard the ill, lest worst may come . . .
 Why not idealize the Doctor some?

He is the master of emotions—he
 Is likewise certain of that mastery—
 Or dare he face contagion in its ire,
 Or scathing fever in its leaping fire?
 He needs must smile upon the ghastly face
 That yearns up tow’rd him in that warded place
 Where even the saintlike Sisters’ lips grow dumb . . .
 Why not idealize the Doctor some?

He wisely hides his heart from you and me—
 He hath grown tearless, of necessity—
 He knows the sight is clearer, being blind;
 He knows the cruel knife is very kind;
 Oft times he must be pitiless, for thought
 Of the remembered wife or child he sought
 To save through kindness that was overcome . . .
 Why not idealize the Doctor some?

Bear with him, prayerful, in his darkest doubt
 Of how the mystery of death comes out;
 He knows—he knows—aye, better yet than we,

That out of Time must dawn Eternity;
He knows his own compassion—what he would
Give in relief of all ills if he could.
We wait alike one Master—He will come . . .
Do we idealize the Doctor some?

—James Whitcomb Riley in Journal of
the American Medical Association.

—O—

BOOK REVIEW.

A Helpful Review. The June issue of *Progressive Medicine* published by Lea Brothers & Co., of Philadelphia, contains 381 pages, and gives a fair digest of recent literature on the subject of Hernia, Surgery of the Abdomen, Gynecology, Diseases of the Blood, and Ophthalmology. Stengel's article on the diseases of the blood and ductless glands fails to enumerate Dr. Langworthy's cases of Addison's disease when summarizing the reports on that disease. This comes, of course, of too great attention on the part of such writers to foreign literature and too little to local American literature. Dr. Coley's article on hernia, in the operating for which he is a past master, and Dr. Foote's article on abdominal surgery in general, are well illustrated. Dr. Jackson of Denver, writes on Ophthalmology. Altogether this number seems one of the best we have seen.

—O—

A synovitis that persists despite careful treatment should arouse suspicion of tuberculosis.—*American Journal of Surgery*.

SOCIETY NEWS.

The Southeast Kansas Medical Society will meet at Parsons Sept. 3. The committee is planning for a big attendance and an interesting meeting. This is one of the district societies that has kept up its organization and made good. It is hoped the attendance will come up to the expectations of the local committee.

At the last meeting of the Reno County Medical Society the regular program was dispensed with and the entire evening devoted to a discussion of the business affairs of the profession of the county, with especial reference to better fee and increased charges for insurance examination. Society adjourned for the summer to begin active work in September. W. F. Schoop, Sec

Topeka, Kans., July 6, 1907. The regular monthly meeting of the Shawnee County Medical Society was held at the National Hotel, Topeka, on July 1st, with Vice President Esterly in the chair.

Dr. W. L. Warriner presented a report of a very difficult labor, in a tuberculous young woman, with all the pelvic diameters greatly lessened. Caesarian section was done with death of child. This report was discussed very freely, many urging the importance of the early use of the pelvimeter.

The paper of the meeting was one by Dr. J. B. Tower on Diet in Typhoid Fever, in which he urged the importance of withholding food during the first few days, thinking it a serious mistake to crowd the early feeding. This paper was freely discussed by every member present.

No business was transacted, and the society adjourned for one month.

J. B. Tower, Secy.

Hiawatha, Kans., July 5. The regular quarterly meeting of the Brown County Medical Society was held July 2nd in parlors of Hotel Grand, Horton, Kans. The attendance was only fair, but each and every person present manifested a keen interest in the welfare of the society and society work. Because of matters of business that came up for consideration, very little time was given to the regular program. After a thorough review of some evidence filed against one of the practitioners of Brown county, the following resolution was submitted to the society and adopted by a unanimous vote:

"We, the members of the Brown County Medical Association,

find after thorough and impartial investigation, that I. L. Meyer, 'M. D.,' of Hiawatha, Kansas, is entirely unethical, unprofessional and dishonorable, and therefore unfit for recognition by any respectable physician."

Society adjourned to meet in Fairview, Kans., at next regular meeting.

L. W. Shannan, Secy.

Goodland, Kans., July 12. The meeting of the Western Kansas Medical Society held at Colby on the 10th inst. was fairly well attended and an interesting program rendered, of which I enclose you copy. Those present were Drs. Eddy, Lewis and Beaver, Colby; Drs. Smith and Carmichael, Goodland; Dr. Stroup, Winona; Dr. Hawkins, Brewster; Dr. Stoner, Quinter, and Dr. Parker, Hill City. The next meeting will be held at Oakley Oct. 9. F. A. Carmichael, Secy.

PROGRAM—MORNING SESSION.

- 9:30 Paper, Cholera Infantum, Dr. J. H. McNaughton, Gove.
Discussion by Dr. Eddy, Colby; Dr. Marsh, Menlo.
- 10:00 Paper, Typhoid Fever, with special reference to its diagnosis and treatment, Dr. E. J. Beckner, Seldon.
Discussion by Dr. Gulick, Goodland; Dr. Lewis, Colby.
- 10:30 Clinical Report of the Recent Epidemic of Cerebrospinal Meningitis at Goodland, Kans., Dr. F. H. Smith, Goodland.
- 11:00 Acute Epidemic Cerebrospinal Meningitis-- History and Review of Recent Current Literature, Dr. Frank A. Carmichael, Goodland.
Discussion by Dr. C. D. Blake, Ellis; Dr. D. M. Forbes, Seldon.
- 11:30 Clinical Reports--1. Some Interesting Cases of Pneumonia;
2. Post Mortem Findings in a Case of Multiple Abscess of the Lung, Dr. H. Austin Stroup, Winona.
- 12:00 Luncheon.

AFTERNOON SESSION.

- 2:30 Paper Cardiac Affections with case reports, Dr. C. M. Miller, Oakley.
Discussion by Dr. Blake, Ellis; Dr. E. D. Beckner, Hoxie.
- 3:00 Acne--Paper and Case Report. Dr. T. F. Howell, Ellis.
Discussion by Dr. Barclay, Grinnell; Dr. Beaver, Colby.
- 3:30 Clinic.
- 4:30 Business Meeting.

Sedan, Kans., July 12, 1907. Chas. S. Huffman, Sec. State Medical Society, Columbus, Kans. My Dear Doctor: As you are the secretary of the State Medical Society, you can better understand than any one else the position I hold and the work it requires to keep things going in the medical family of the county.

For over thirty years efforts have been made from time to time to organize in this county. I have lived in this county for the past 29 years, spent my boyhood days here, have associated with the doctors here and know much of their peculiarities.

I have been in practice in this county for about twelve years. In former times was a school teacher. If you will look over your files you will see that I was appointed secretary last October by Dr. L. S. Trusler. I paid no attention to it whatever until some of the doctors from Cedarvale wrote over and requested me to advertise a meeting. This I did. We met, only five of us, the first Monday in February, and organized. Dr. G. W. Goss as president, and myself as secretary. I went after it in my own way and advertised each meeting, writing from four to five circular letters during the month. Enclosed find a sample of one of those letters.

There are only about fifteen doctors in active practice in the county and of course it has been hard to make some of the doctors understand that it was impossible to have a large turn out at our meeting when we did not have the doctors to turn out, and that we were lucky to have a quorum on an average.

Some of the boys have not been receiving the State Journal, B. E. Garrison of Sedan, and B. F. Finn of Cedar Vale. Look over the list of members and see that all paid up, not honorary members, are receiving the Journal.

We have had a full quorum ever since our first meeting in February except one. Five meetings. I think for so few doctors and so widely scattered and poor railroad accommodations that we have done fairly well. Our next meeting will convene in Peru, Monday, Aug. 5. One thing I must inquire about: A doctor who has recorded his license in one county and moves to another county in Kansas should he not again register in the county clerk's office?

Now doctor, I have been somewhat lengthy in this report. You can shorten it and give us a report in the State Journal next month. I am doing my best to consolidate the profession in this county and think we are in a degree succeeding. Respectfully,

Milton T. Evans, Rec. Sec.

Report of Council on Pharmacy A. M. A.**IODIPIN 25 PER CENT.**

A preparation similar to the preceding, but intended for hypodermic administration.

Dosage.—2 to 6 Cc. (30 to 90 minims) by hypodermic injection. This article is also marketed in the form of capsules, each containing 2 Gm. of iodipin 25 per cent. Prepared by E. Merck, Darmstadt. (E. Merck & Co., New York.)

ODOFORMOGEN.

A nearly odorless mixture of iodoform and albumin.

Actions and Uses.—Its action is that of iodoform, which is slowly liberated in connection with wound surfaces, making the action more persistent. It limits secretion, favors granulation and promotes drying. Iodoformogen is recommended as a dusting powder for ulcerated surfaces. Dosage.—Being about three times as voluminous as iodoform, it is usually applied undiluted to the affected parts. It may be used as a snuff in ozena, mixed with an equal amount of boric acid. Manufactured by Knoll & Co., Ludwigshafen a. R. and New York.

IODOTHYRINE.

Iodothyrene is a milk sugar trituration of the active principle of thyroid gland, 1 Gm. representing 1 Gm. of fresh gland and containing 0.0003 Gm. of iodine.

Actions and Uses.—It is similar in action to Glandulae Thyroideae Siccae, U. S. P., but it is claimed to possess the advantage of more definite strength and absence of decomposable extraneous matter. Dosage.—Adults, 0.6 to 2 Gm. (10 to 30 grains); children, 0.3 to 1 Gm. (5 to 15 grains) per day. Manufactured by Farbenfabriken, vorm. Friedr. Bayer & Co., Elberfeld, Germany (Continental Color & Chemical Co., New York). E. Merck, Darmstadt (Merck & Co., New York.)

ISOFORM POWDER.

Isoform powder is a mixture of para-iodoxy-anisol, $C_6H_4(OCH_3)(IO_2)$ 1:4 = $C_7H_7O_3I$, an iodoxy-derivative of anisol, with an equal weight of calcium phosphate.

Actions and Uses.—It is a germicide and antiseptic in consequence of its oxidizing power and in contradistinction to iodoform, it acts not only in a medium free from oxygen, but in conjunction with free access of air. It is claimed to be non-toxic in comparatively large doses and to be absolutely non-irritant to the unbroken skin. It is recommended as a substitute for iodoform. Dosage.—

Internally, 0.65 to 2 Gm. (10 to 30 grains) per day. It is used externally as a dusting powder, as a paste with glycerin, as ointments, suspensions in glycerin, gauzes, etc., in strength varying up to 10 per cent. of pure isoform. Manufactured by Farbwerke, vorm. Meister, Lucios & Bruening, Hoechst a. M. (Victor Koechl & Co., New York.)

ISOPRAL.

Isopral, $\text{CCl}_3\text{, CHOH. CH}_3\text{=C}_3\text{, H}_5\text{, OCl}_3$, is L. L, L-trichlor 2-propanol.

Actions and Uses.—Isopral resembles chloral in its action, but is effective in smaller dose. It is prompt in effect and apparently devoid of cumulative action. It has some degree of local anesthetic power. It may be used as a substitute for chloral hydrate and is servicable as an alternative in cases in which it is necessary to give hypnotics for a long time. Dosage.—0.3, 0.6 to 1 Gm. (5, 10 to 15 grains) in capsules or wafers which should be dispensed in well-stoppered glass vial. Manufactured by Farbenfabriken, vorm. Friedr. Bayer & Co., Elberfeld, Germany (Continental Color & Chemical Co., New York.)

KASAGRA.

A fluid extract said to conform in drug strength to the requirements of the U. S. Pharmacopeia for fluid extracts. It is prepared with especial care, the drug being extracted with a menstruum containing no alcohol. The preparation is said to contain 0.05 per cent. of alcohol.

Actions and Uses.—Kasagra is recommended as an especially palatable preparation of cascara, owing its laxative effects to this drug alone. Dosage.—1 to 2 Cc. (15 to 30 minims) four times a day, half an hour before meals and at bedtime. Prepared by F. Stearns & Co., Detroit, Mich.

KOLA, Stearns.

Each 30 Cc. (1 fluid ounce) is said to represent 31 Gm. (480 grains) of fresh kola nut. It contains 23.5 per cent. of alcohol.

Actions and Uses.—Kola seeds contain from 1.5 to 3.6 per cent. of total alkaloids of which from 1-100 to 1-40 is theobromine and the rest is caffeine. About one-half of the caffeine is combined as kolatannate of caffeine. The actions and uses of the remedy are essentially the same as caffeine. It is probable that the kola-tannate is not so active as free caffeine. Dosage.—2 to 4 Cc. ($\frac{1}{2}$ to 1 fluidram) three times a day. Prepared by Frederick Stearns & Co., Detroit, Mich.

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SURGERY OF THE ETHMOIDAL SINUS

By J. E. SAWTELL, M. D.

Professor of Rhinologyngology, University of Kansas, Kansas City.

Surgical intervention in ethmoidal sinus affections has been, until very recent years, a matter of hesitation and uncertainty on the part of the rhinologist. It was not until after the very exhaustive anatomical research work done by Zuckerkandl, of Vienna, that surgery of the accessory sinuses of the nose began to gain rank with scientific surgery of other parts of the body. It need only be mentioned, then, that a most thorough and comprehensive knowledge of the anatomy of the ethmoidal sinus and of its important relations to other parts is the foundation upon which all extensive operative work must rest if successfully done.

The ethmoidal sinus is composed of an inconstant number of cells with almost infinite variations as to size, shape and contour, not only in different individuals but in the two sides of the same nose. According to locality and drainage these cells are divided into two groups. Those located anteriorly and draining into the middle meatus are called the anterior ethmoidal cells, while those situated posteriorly and draining into the superior meatus are called the posterior ethmoidal cells. The anterior ethmoidal cells are in proximity to the frontal sinus, the naso-frontal duct and the hiatus semilunarius; while the posterior ethmoidal cells are closely related to the sphenoidal sinus and the antrum of Highmore. Transversely, the ethmoidal cells lie between the external wall of the nose and the os

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planum, or orbital plate of the ethmoid. The thickness anteriorly is only about one-fourth of an inch, while posteriorly it is fully half an inch. A thin plate of ethmoid bone separates these cells from the anterior lobe of the brain.

In viewing a cross section of the ethmoidal cells, it will be seen that two very important cavities are closely related: the brain cavity above and the orbital cavity to the outer side.

On account of the frequent necessity for operations upon the ethmoidal cells, and the danger of doing harm to the eye and the brain, it is important to have in mind certain landmarks from which the operator may work without incurring danger to the patient. If the anterior end of the middle turbinate is removed or shoved inward from its usual position the large space known as the middle meatus will come into view. On the outer wall of this meatus, extending downward and backward, there is rather a deep sulcus, or ditch, called the hiatus semilunarius. This sulcus is bounded anteriorly by a bony prominence which is known as the processus uncinatus; behind, by a larger and more or less globular shaped bony wall known as the bulla ethmoidalis. These structures are always present on the external wall and are only a short distance from the inner wall of the orbit. They are safe landmarks from which the operator may work without danger if the proper course be maintained throughout the operation.

The bulbous prominence lying immediately beyond the hiatus semilunarius is the largest of the anterior ethmoidal cells. By removing a small portion of the lower and inner wall of this and adjoining cells, sufficient drainage may often be secured without sacrificing any portion of the middle turbinate; but if the anterior cells are extensively diseased, the anterior portion of the middle turbinate must be removed. In order to make a thorough and complete removal of the posterior cells it is necessary to take away the anterior end of the middle turbinate, then its base until the superior turbinate is reached, which, in reality, is composed of posterior ethmoidal cells.

In doing operative work on the ethmoidal cells one should keep steadily in view two planes: one a perpendicular which should be a safe distance from the orbit; the other a horizontal which should be a safe distance from the brain. Any of the tissues then falling within the angle formed by these two planes can be removed until the sphenoid bone is reached posteriorly.

Surgical intervention of the ethmoidal sinus is usually made necessary by either an open or closed empyema of one or more of

the cells. By an open empyema is meant a diseased cell or group of cells from which there is little or no obstruction to drainage, while in a closed empyema the discharge is retained within the diseased area. An open empyema, like a discharging ear, may at any time become closed, and this is especially true after an attack of influenza.

The diagnosis of an open empyema is made by the location of the discharging pus. If pus is found discharging into the middle meatus it is safe to conclude that it is coming from either the antrum of Highmore, the frontal sinus, or the anterior ethmoidal cells. The opening into the antrum is lower down and usually posterior to those of the other two sinuses, so if the pus is carefully cleansed away and it is seen to continue to flow from higher up, then this sinus may be excluded. If, now, the naso-frontal duct is securely blocked with a pledget of cotton, and pus continues to flow into the hiatus semilunarius, it is reasonably certain that there is an involvement of the anterior ethmoidal cells. If, on the other hand, it is discovered that pus is flowing down over the inner or septal side of the middle turbinate it must be coming from the superior meatus into which the posterior ethmoidal cells and the sphenoidal sinus have their drainage. A careful examination of the naso-pharynx should next be made by means of the rhinoscopic mirror, and if pus is seen flowing from the ethmoidal sulci, it may be concluded that it is an open empyema of the posterior ethmoidal cells that demands attention.

In closed empyema of the ethmoidal cells pain, instead of pus, is the predominating symptom. Severe and prolonged frontal or occipital headache, facial neuralgia, pressure over the bridge of the nose, cerebral disturbances, lack of mental concentration, nervousness with a tendency to neurasthenia, are symptoms common to involvement of either the anterior or posterior ethmoidal cells.

Pus being retained within the diseased cells, they become enlarged and force the middle turbinate inward toward the nasal septum. When the anterior cells are involved they may be found bulging downward and inward, as this is the direction of least resistance.

A closed empyema of the posterior ethmoidal cells is more likely to perforate the orbit than a similar involvement of the anterior cells; while a perforation of the brain is more apt to be the result of a closed empyema of the anterior cells.

Occasionally, a closed empyema of the anterior cells does not find exit either into the brain or nose, but forms an enlargement along the inner orbital wall above the inner canthus.

A man about 55 years of age came into one of the University

clinics, suffering from nasal trouble. He had had a purulent discharge from both nasal cavities for several years; but at that time was complaining of quite a little discomfort from the left side. On the inner orbital wall on this side and just above the inner canthus there was an oval bony outgrowth, which, according to the history, had been there about ten years. Intra-nasal examination revealed a flow of pus from the frontal sinus. The anterior ethmoidal cells were very much enlarged, displacing the anterior portion of the middle turbinate inward against the nasal septum. After cocaineization, all the diseased cells were freely opened with a cutting forceps, which allowed a copious discharge of pus. The parts were cleansed and left open for drainage. In one week, when the patient returned, the bony prominence had entirely disappeared.

Closed empyema frequently occurs in the accessory cells of the middle turbinate, when the tendency is then to remain circumscribed. This condition is not usually discovered unless the end of the turbinate is large enough to necessitate removal.

The following case report well illustrates this condition:

A station agent, aged 35, from Arkansas, came under treatment September 28, 1905. He had been suffering for about four years from headache, pain about the left eye and left frontal region, and a feeling of pressure over the bridge of the nose. He was at that time suffering from insomnia and had become very nervous. His power of mental concentration had become so shattered that he was in fear of having to give up his position. He had consulted a number of physicians, but all had assured him that no nasal trouble existed. After cocaineizing the left nasal cavity, the bulla ethmoidalis was found to be slightly enlarged, pressing the anterior end of the middle turbinate against the nasal septum, which was somewhat deviated to the left. With an applicator, the anterior end of the middle turbinate was pressed away from the septum, when a large, oval, bony outgrowth, pressing firmly against the septum, came into view. The anterior portion of this turbinate was removed, which was found to be healthy; then, with cutting forceps, a further portion of it was removed, until the oval enlargement was reached, which was found to be an enlarged accessory cell filled with pus. The bulla was then inspected, in which was found a small polypus and some pus. Both cavities were gently cureted, irrigated and packed with sterile gauze, which was allowed to remain twenty-four hours. The further treatment consisted of daily irrigations. It was interesting to note the immediate cessation of all his former suffering and discomfort. In a letter received from him some months later,

he expressed his appreciation of the continued relief.

On account of the closely related positions of the bordering ethmoidal cells to the frontal, maxillary and sphenoidal sinuses a chronic supuration within the cells of the former is nearly always followed by a similar affection of one or more of the latter neighboring cavities.

In the great majority of cases, the ethmoid cells become diseased first and from these the other sinuses become infected.

An infection of the sphenoidal sinus is almost invariably the result of an empyema of the posterior ethmoidal cells.

In a closed empyema of the posterior ethmoidal cells where there is no flow of pus to attract attention, the affected cells being inaccessible for direct rhinoscopic exploration and the symptoms also being so varied and obscure as to give no definite indication of the true nature and location of the disease, the diagnosis is rendered most difficult.

The following case is of unusual interest from a diagnostic point of view:

A lady, aged 47, had always been in good health up to August, 1904, when she received a septic infection of the left eye, which was of marked severity, running a protracted course and resulting in an iritis followed by adhesions. After recovering from same, which had continued for about two months, she remained in ordinary health until August, 1906, when she commenced to lose flesh and decline in health. About November, she began to suffer from periodical headaches, pain about the eyes and pressure over the bridge of the nose, all of which continued to grow worse. In December, she consulted an oculist who attempted to give relief from properly fitted glasses, but without results. The pain and other symptoms became constant and so intense that large doses of opiates were required to give rest. The suffering was now confined to the left side of the face and head, the pain radiating from the left orbital region. Brain trouble was suspected, as there was some mental disturbance, and a specialist on mental diseases was called, but no relief was obtained. Two or three internists were then called in rotation, but no correct diagnosis was made.

On December 2, she returned to her oculist and this time a diagnosis of glaucoma was made, but she continued to grow rapidly worse. She next came under my care, on January 1, 1907, when she was very much emaciated and exhausted and presented a general septic condition. For several days she had been having nausea, occasional vomiting, slight rigors, fever, and some disturbance of

vision in left eye. Anterior rhinoscopic examination revealed nothing positive, but a careful examination of the naso-pharynx with the rhinoscopic mirror brought into view a small mass of granulation tissue in the region of the ethmoidal sulci. Under cocaine anesthesia the posterior portion of the middle turbinate was removed when a large quantity of thick, creamy pus was evacuated. With cutting forceps, the posterior ethmoidal cells were freely opened and all necrotic tissue was removed, as far as possible. The sphenoidal sinus was involved also but the condition of the patient at that time would not permit any further operative measures. The parts were left unpacked to allow free drainage. The after treatment consisted of irrigations with a solution of boric acid. The normal opening into the sphenoid sinus was found to be sufficiently large to allow free irrigation and drainage of this cavity, so no further operation was required. It was gratifying to note the immediate relief from all pain following the operation. Her former health was soon regained and the discharge from both cavities had entirely ceased by the end of six weeks, and there has been no return of the trouble.

The necessity for performing other than an intra-nasal operation for diseases of the ethmoidal sinus is extremely rare. In neglected cases of tertiary syphilis, involving the anterior ethmoidal cells, where necrosis is extensive, external operative measures may be required. Diseased anterior cells may so obstruct drainage through the naso frontal duct as to cause frontal sinus disease, for the relief of which external operation might be required; but this would be for the relief of a complication.

Pus enclosed in the ethmoidal cells may extend to a locality where severe ocular symptoms, such as tenderness, pain, swollen and reddened condition of the upper lid, and marked exophthalmos may be produced; but unless it can be definitely determined that pus has already made its entrance into the orbital cavity, an intra-nasal operation should be selected.

The thoroughness with which the after treatment of ethmoidal operations is carried into effect is of much importance. The patient should remain indoors for the following twenty-four hours and in bed, if the operation has been extensive. The mere spraying or douching the nasal cavity with any cleansing agent that might be selected is good home treatment, but not that which should be relied upon by the surgeon. After forty-eight hours and every day thereafter as long as conditions indicate the necessity, the operative field should be inspected and dressed. The main purpose of

the operation is two-fold: First, to remove all necrotic tissue; second, to open all diseased cells in order to permit free drainage. If the discharge should continue to be profuse, it would indicate that the entire diseased area had not been reached, then the source should again be observed and the first attempt supplemented by further surgical intervention.

The operation having been performed in a manner as radical as the demands, then, with scrupulous attention to the after treatment, there is little to anticipate other than a successful and satisfactory termination of all unpleasant symptoms.

—310 Rialto Building.

DISCUSSION.

Dr. Wever:—The doctor has written the kind of paper I like to come to the medical society to hear. He got right into the middle of his subject at the start; and told us things that we ought to know. There was one paper read yesterday that took about twenty minutes for the introduction and about ten minutes for the completion. That is not the kind of paper I like to hear. There was one thing I would like to emphasize and that is—polypus. I do not think the doctor laid quite stress enough on the fact that an empyema of the ethmoidal sinus is liable to cause polypus. One of the old theories used to be that the turbinate bones were diseased. The general practitioner is liable to call any obstruction in nasal breathing catarrh, or any discharge from the nose, a catarrh. Catarrh is a term that like charity covers a multitude of sins. I do not think there is enough use of the head mirror and speculum to find out just what is the matter. The treatment as outlined by the doctor is entirely correct. Treatment by the atomizer is entirely inadequate.

Dr. Sawtell:—I am sorry that the paper did not receive more discussion; but, I realize that these papers on special subjects are not generally appreciated. That is one reason I did not want to inflict it on a tired audience. I thank Dr. Wever for the kind remarks he has made about the paper.

Dr. Lyman:—Dr. Sawtell is entirely wrong in thinking that his paper was not appreciated. I listened with intense interest. I was simply overcome. I do not know anything about it.

Dr. Hayes:—I want to correct Dr. Sawtell, too. I have no doubt that every physician appreciated the paper highly. I wish to express my appreciation of it. It is not the paper that is the most discussed that is the most appreciated.

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The American Public Health Association will hold its thirty-fifth annual meeting September 30th to October 4th, at Atlantic City, N. J.

THE PRESENT AND COMPARATIVE STATE PHYSICALLY OF THE AMERICAN PEOPLE.

By RALPH A. LIGHT, M. D., Chanute, Kansas.

Are we progressing or retrograding physically?

Is our tendency, at the present day, to develop the mental at the sacrifice of the physical?

A few pertinent facts relative to the increase of certain diseases and their tendencies, which continued will reduce the physical and mental qualities of our race.

In presenting this subject before the medical fraternity I do not intend to put forth all the facts relative to the various phases of the conditions to be discussed as such would be impossible and impractical in the brief time allotted me.

The purpose of this discussion is to enlist your sympathetic thought in a matter of vital interest to us as physicians in our dealings with humanity as we see it daily. I can touch only upon a few of the salient points relative to this extensive subject. Neither is there any claim that the conclusions deducted will be entirely correct, but it is to be hoped that they will be so in the main, and that much good may result from this presentation and discussion.

Physical man owes his existence to the Creator who moulded him from the earth's substance after His own likeness and breathed into his nostrils the breath of life, and pronounced him perfect and good to look upon. Historically, man seems to have retained very much of this physical perfection for hundreds of years after his creation and banishment from the garden. According to biblical statements such patriarchs as Seth, Enos, Jared, and Methuselah attained ages which makes the duration of our life dwindle into insignificance.

Our average expectation of life at present is near 33 years. This average is subject to slight variation either way. It is a doubtful question as to whether the expectation of life of those who reach adult age is appreciably lengthened at the present period. Statistics upon this subject are variable, and not to be absolutely depended upon, but it is not the intention to delve deeply into them but enough so that we may get at the main facts relative to our subject.

The English vital statistics are the most reliable because of their completeness and accuracy in reporting births, deaths and diseases. The contrary seems to exist with us except in ten different states. We are very tardy in enacting stringent laws relative to the accurate compiling of our vital statistics.

Expectancy of life (English statistics) starting with the year naught has increased $3\frac{3}{4}$ years in a period covering 52 years. You will notice the following: Expectancy of life relative to those who have attained the age of 20, covering the same period of 52 years has increased only 79-100 of a year. It is more than likely that this lengthening of life expectancy starting with year naught is due to the saving of infantile mortality. If we assume that the gain in the expectation of life at the year naught, as indicated above, has been due to a lower infant mortality; thus the infants saved, are probably of a lower vitality than those which formerly survived when the infant mortality was higher. The lower vitality of those thus saved would naturally lead to a somewhat higher mortality during the adult life which would account for the fact that the expectation of life in adult ages has not perceptibly lengthened. Of course infant mortality has been reduced by our advanced skill in handling, treating and preventing disease. On the other hand adult mortality has not increased appreciably, in fact if we may judge anything from statistical reports for the past five to ten years, we are becoming a ready prey to certain diseases and the mortality is higher. With all our knowledge concerning the science of medicine and hygiene we apparently are no better regarding disease and death than formerly.

The statistics, from which the deductions following, are based upon the mortality tables of the census bureau and the statistics of the twelfth census. They are not infallible but in the main give results that should be fairly accurate. The registration area from which these facts are gleaned consists of Connecticut, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Rhode Island and Vermont.

It needs no statistics to tell you that where there is an over crowded condition, a superabundance of the lowest type of laboring classes, where there is most general pauperism, where signs of bad environment, like phthisis, are most abundant and where pauper lunatics are most common. the wives of reproductive ages have the most children. Where there is more culture and education, as shown by a higher proportion of professional men, where there is more comfort and leisure, as shown by a higher percentage of

domestic servants, there the birth rate is lowest. Wives in districts of the least prosperity and culture have the largest families and the morally and socially lower classes of the community are reproducing themselves with the greatest rapidity. With our advanced civilization and acquiring of wealth comes luxury and love of pleasure. With the possession of money physical labor ceases. Because children are a hindrance to what they consider pleasure, rich women do not desire them, neither will they have offspring if they can prevent it. They will stoop to anything to cause abortion.

Here is where I wish to impress upon you the powerful, all pervading influence upon us as a people and individuals of heredity. If we fail to use our bodies the result is deterioration both physically and mentally. If we fail to use our talents it shows in our posterity. The meaning of heredity as defined by Bradford: "Is the law through which the individual receives from his parents by birth his chief vital forces and tendencies, his physical and spiritual capital." The great fundamental law of heredity is that like produces like. As expressed by Darwin, "The tendency is to produce an exact copy of parents in offspring." This law is modified by a secondary law, namely, that the acquired characteristics of one generation are transmitted to the next. Thus you see that heredity plays an important part in giving us healthy or weakly bodies with good or deteriorating tendencies.

A recent report of a special committee on criminal abortion in Michigan contains this statement. To so great an extent is abortion practiced by American Protestant women that by a calculation of one of the committee based upon correspondence with nearly 100 physicians, there comes to the knowledge of the physicians 17 abortions to every 100 pregnancies.

To these the committee believe may be added as many more that never come to the physician's knowledge, making 34 per cent or 1-3 of all cases ending in mis-carriage. The greatest immediate cause of epilepsy and feeble-mindedness, particularly the former, is the use of poisonous drugs for the prevention of conception and in the production of abortion. It is estimated that no less than 32 per cent of the 300,000 epileptic and idiotic persons in the United States have been so caused. This means that 96,000 of these unfortunates have been produced by willful violation of nature's laws. This is not pleasant to recite to a highly cultured audience, but we know too well the above mentioned is true. What an abuse has come to the physician and his skill and science in the uses of medi-

cine and surgery. What will the following generations be?

Within the last 25 years insanity like epilepsy and feeble-mindedness, has increased at an alarming rate. It has quadrupled in the United States. Of the many causes of insanity alcoholism is perhaps the greatest, while morbid heredity ranks next. Insanity is largely the result of degeneracy. Most persons who have become mentally deranged are the offspring of neurotic, drunken, insane, feeble minded, scrofulitic or consumptive parents.

There is an increased death rate, comparing five years, 1900 to 1904, in the following groups: heart disease, nephritis and Bright's disease, diabetes, appendicitis, tuberculosis (all forms), venereal disease (syphilis and gonorrhea), tumors, rheumatism and epilepsy.

It is the opinion of the Secretary of the Kansas State Board of Health that tuberculosis, all forms considered, is unquestionably on the increase.

There is positive evidence that there is a regular increase in the death rate year after year from two classes of causes, consisting of disease of the circulatory system and genito-urinary system. Diseases of the circulatory system includes pericarditis, endocarditis, heart disease, angina pectoras, hemorrhages, embolism, thrombosis, disease of the arteries, veins and lymphatics.

The above mentioned groups show an increase in five years of 12,000 cases or 26 per cent.

Disease of the genito-urinary system shows an increase of 17 per cent for the same period of time and area of registration.

Cancer has increased 4,000 cases for the same period and registration area.

Diabetis has doubled.

Pneumonia has this past winter caused a greater percentage of mortality than ever before. This report is recently from Indiana and Chicago.

Everywhere is the taking of life by suicide increasing.

I have endeavored not to burden you with tables and figures but have diligently compared them and simply given you the results in the above.

You may reply to these statements that the apparent increase of these diseases may come from an ability to better and earlier diagnose them. If you should make such a statement please bear in mind that these conclusions and figures cover a period from 1900 to 1904, inclusive. We have been as skillful in diagnosis in this period as any. Surely it cannot be said that this increase is entirely on account of a better and earlier diagnosis. This increase

amounts to 17 per cent in one case, 26 per cent in another and 50 per cent in another. Such increases we cannot help giving notice.

I have endeavored by the foregoing statements to show you that as a typical American people we are on the verge, if not already, retrograding physically. In your comparisons do not select any one class of individuals but you must draw your averages and conclusions both from the individuals who exist by their brain work and those who do so by their physical bodies.

Average those living in the manufacturing and mining centers and their offspring with those of the farming class of the West.

As our eastern states are the more thickly settled, so is the death rate higher from most every disease. Consequently the inhabitants where the thickly populated centers exist, where labor indoors is the principal occupation, you will see the poorest physical development, the least hardy, the class who has the least resistance to disease. Their offspring are sickly, poor specimens physically by birth, if not they are made so by the necessity of working during their entire period of development. It is impossible for them to develop into healthy, robust individuals even should they inherit such a tendency. Like begets like and the acquired tendencies are transmitted to each succeeding generation. What can we expect from the thickly populated manufacturing and mining centers but degeneracy physically. I think this correct that as our so-called civilization advances so does disease in like ratio. I do not believe we have the vital power to resist disease we formerly possessed in years or generations past. Is not tuberculosis on the increase? Is it not our greatest enemy? And will it not continue to be as time continues, unless we educate the present and following generations on the great importance of possessing better physical bodies? There should be, and we will live to see the day when there will be, laws regulating marriage, which will require a certain physical standard. I cannot see if we do not have some such requirements but that we will degenerate physically.

Dr. Winfield S. Hall, professor of physiology of the Northwestern Medical School, is quoted as follows: "There is no doubt but that in certain of our physical features we are retrograding, e. g.—the alveolar arch is from century to century contracting and its armament of teeth is getting from decade to decade appreciably weaker. Dentists tell me that this may be attributed largely to the fact that we are eating fine grained and soft foods while our ancestors ate coarse grained and hard foods. It requires the coarse, resistant foods properly to preserve the strength of the teeth, therefore the degeneration."

Another case may be cited in the gradual degeneration of the little toe in all of those people who incase their feet in shoes. The little toe is destined within a few centuries to become simply a rudimentary growth on the side of the foot.

The growth of the hair is from generation to generation becoming less luxuriant. This is particularly marked in the male population although it is also marked to a lesser extent in the women.

If these retrogressive changes above noted continue for an indefinite period the race will be a baldheaded, toothless race with four toes and a protuberance on each foot. In the meanwhile the cranial measurements are becoming somewhat greater, indicating a gradual development in the size of the brain.

The cranial measurements of the human foetus are greater in the highly civilized people of the North Temperate Zone than in the half-civilized and savage races, indicating that the human brain is by civilization and education becoming gradually larger, requiring a larger cranium to hold it. This in turn subjects the parturient canal to increasing dangers of ruptures and other damages which tendency is abundantly evidenced in the practice of obstetricians and gynecologists of these big-headed nations.

These views are radical and too highly colored you may think, but whether such is the case or not, certainly you can see danger signals displayed.

Our greatest enemy, and one which is as yet recognized by but few, and which is underminng us physically and causing a continuous state of mental unrest, is the universal desire to acquire great wealth. No standard is too high, no sacrifice too great to attain the much coveted goal. We are not a pleasure-loving people. We are possessed with the insatiable desire for gain to the exclusion of all else. The average young man and woman are wont, at the present day, to neglect their physical development to an alarming degree.

What the youth of the land need at the present time is not the development of greater bulk of bone and muscle, but the development of greater agility, accuracy and grace of movement. These attributes can be developed only through the participation in games in which the individual is pitted against individual or team against team. There is a misunderstanding on the part of many as to the practical value and limits of physical training and its relation to mental training. They do not know that exercise develops the brain as well as the muscle. There exists a mind brain and a body brain. We cannot have a healthy, active brain with a poor, sickly body.

Why do we have an increased death rate from certain diseases? Principally, I claim, because most individuals place little or no importance upon the development and preservation of a good physical system. Another is that we pay so very little attention to the influence of heredity upon the offspring of to-day. How many children come into this world under the proper influences? Not many, comparatively. Consequently, can we expect to maintain any sort of physical perfection under such influences? How are we to reduce insanity, epilepsy and tuberculosis? To my mind we certainly are developing the mental to the sacrifice of the physical and while you may not see anything particularly alarming at the present state, physically, there must be a change in our tendencies, a halting in our mode of living at the present day, in order to preserve ourselves as a distinct American type. We must devote more time to pleasure, less to the accumulation of the material things of this world, and more to a better heredity.

DISCUSSION

Dr. Minney:—I believe the wrong man read that paper. It does not sound well from an athlete. It should have been read by a skinny man like me. It would have had a better effect. I do not know but it is better to live forty years and do something than to live nine hundred years, as did Methuselah and live the life of a sponge—live, breathe and die. Specific diseases are doing as much as anything else to destroy mankind. They bring as a result various diseases, insanity, etc. These physicians are in a position to reduce by teaching. The young should be educated along this line. Respecting filth: I do not know that filth is particularly against human health. Who ever saw a poor sewer rat? They are all fat. Where a family has one or two children, as a rule, they are not strong and healthy as they are when there are fifteen to twenty. Now, you have doubtless heard of a man by the name of Roosevelt. Dr. Goddard, have you or the honorable chairman heard of him? This man Roosevelt, whoever he may be, says that there is race suicide wherever there is a family of not more than two children. We degenerate. There must be four children in order to keep from degenerating. I have not come up to quite the standard, I must admit. The doctor says we are all going to become web-footed. Well, I am a minney and I can swim.

Dr. Johnson:—The doctor does not need to put Dr. Light in Roosevelt's class. He got up and read a paper promoting those ideas, you all know; but, he has nothing whatever at home to show for it.

Dr. Jones:—There are some good points in the doctor's paper. There is one point, however, that I want to introduce into the discussion. I do not want it to go unchallenged in the Kansas Medical Society. That is, that the acquired traits of the parent are transmitted to the offspring. I do not believe it. As to the necessity of looking after the offspring: I think one of the greatest crimes that is being committed to-day is the way school girls are crowded through our high schools; not so much harm is

done in the University life as in the high school life. At twelve to eighteen years of age, a girl is crammed with knowledge and her power used up in that manner at the time that she is elaborating a most complicated reproductive system. Right there is where our future generation is going to be weak.

Dr. Minney:—Did I understand you in your first statement to say that "I do not believe that the acquired characteristics of the parent are transmitted to the offspring?"

Dr. Jones:—You did.

Dr. Minney:—We have had an experience that I wish to mention. We have taken a little girl to raise. She never knew her father or mother; yet, she is just as similar to her mother as can be—in appearance, in behavior, even to the anger that she shows. Now, if you mean that, I want to dispossess your mind of the idea; for, it was certainly so in this case.

Dr. Jones:—Those are not acquired traits.

Dr. Reynolds:—I enjoyed the paper very much. It takes in a subject that is full of thought, one that should engage the mind of every human being that occupies the earth to-day. It is a matter that goes back farther than the present generation. The laws of nature are immutable and unchangeable. If our ancestors lived longer than we do, it was one of nature's provisions. At the time of their lives, our earth was uncrowded. They had free access to the whole world. They had not the surroundings that we have. They lived a different life entirely. Instead of having their grain ground for them, they ground it with their teeth. They lived the life of the American Indians. It was one of Nature's laws that they should live under conditions that would never obtain now. If they lived as we live now, they would have perished before our time came. Now, that we are crowded, it is just as much in harmony with nature's laws that we should live a shorter time, less we be overcrowded. Of course, there have some unnatural things crept in as our natural means of hastening our natural end. As the medical profession, it is the natural thing for us to control that. In limiting our offspring, we have controlled it somewhat. More than half of us, almost all of us, have just happened. We were not wanted, as a general thing. I happened to be the lucky fellow that did not get shoved over.

Dr. Walker:—I enjoyed that paper very much. Perhaps I am not, as Dr. Minney said, a very good representative of this paper. However, I have gotten along very well, and expect to live a good many years yet. It was a fine paper. I wish we might have more like it. I believe that the cure for this state of affairs is getting these things before the laity. I believe the cure is in a broad education that shall extend to our public school system. I believe that if these things were taught the boys and girls and they were given this knowledge from a high ethical standpoint instead of hearing it from associates and acquaintances in a low sort of a way, it would help us to make better men and women of our children. I want to say one thing about Methuselah: He lived to be 150 years old and from that time on until he was 969, he begat sons and daughters!

Dr. Light:—Dr. Minney is all right. His sewer rat is a good illustration, for his rat will be healthy if it has good air and plenty of it.

Dr. Jones, if you do not think that the acquired traits and tendencies are handed down from one generation to another, I want you to investigate a little. You will find out differently. I thank you, gentlemen, very much.

Dr. Uhls:—Eighty per cent, probably more, of all cases that become insane are traced to heredity.

A little more time and milder measures will eventually bring more satisfactory results and a safer termination in gonorrhoea.

It is a good rule to have all ointments made extemporaneously, as they can be better adapted to the case and the ingredients be fresh.

When the pubis and neighborhood itch look for animal parasites. The writer has seen a patient treated for eczema when the cause was the pediculosis pubis.

Itching is not a symptom limited to scabies, lice and eczema. There are many inflammatory, as well as parasitic diseases, in which itching is a prominent symptom.

Lupus vulgaris is also due to the tubercle bacillus, and requires strenuous measures in its treatment. The Roentgen-ray treatment will bring about rapid cicatrization and, later on, carcinoma is apt to develop in the scar.

The Thirty-third Annual Meeting of the Mississippi Valley Medical Association will be held at Columbus, Ohio, October 8, 9 and 10, 1907, under the presidency of Dr. H. Horace Grant, of Louisville, Ky. The orator in medicine will be Dr. George F. Butler, of Chicago, Ill., and the orator in surgery, Dr. Frank D. Smythe, of Memphis, Tenn.

THE EARLY TREATMENT OF INSANITY.

By S. S. GLASSCOCK, M. D., Kansas City.

Early treatment of insanity from the standpoint of the alienist is one of the most important things in medicine. In medicine and surgery the public seek competent help at once and by so doing make it possible to obtain the best results. Delay in the proper handling of these cases would rob medicine and surgery of their brilliant achievements. The past twenty-five years has done more in these lines than could possibly have been dreamed of by the most visionary man. What has been done in these can be done in psychiatry under like conditions. And is, in a measure, being done. The sick brain when being viewed from its proper standpoint calls for early treatment; the longer the delay the less likelihood there is to effect a cure. In the mad rush to gain wealth the American people sacrifice all on the altar of ambition. In our great centers of commerce, great institutions become great by wrecking the lives of some of the men who built them; men gain wealth or distinction by sacrificing nerve energy. Every state has its thousands of insane, made so in part by unreasonable efforts to gain wealth or distinction. The cares of modern life are too great an effort for many women and they add to the list in large numbers. The marrying of men and women who must of necessity produce children with insane tendencies, adds another large list to the ever increasing number of the insane. The care, by the states, of these cases becomes an enormous expense, even when reduced to the lowest possible cost. To separate the acute curable cases and provide a suitable place for their care and treatment is one of the urgent needs of the present time. The men in charge of the state institutions realize how difficult it is to do this. Private institutions are in a measure doing this. Here the desire to make money is likely to endanger their success. When that is the case they will likewise fail to produce the results desired. Buildings and equipments to properly care for such cases cannot be constructed and equipped for less than fifteen hundred dollars per case. When we add to this competent medical men and qualified attendants and the other necessary expenses these institutions can care only for a limited number of those needing care and treatment. The rest must be provided for by the state or in some other way yet unprovided. Seclusion and rest for these cases is of first importance.

Read at the forty-first annual meeting of the Kansas State Medical Society, May, 1907, Kansas City, Kansas.

Visiting by friends and relatives should not be permitted as it cannot be otherwise than harmful during the acute stage at least. The diseased minds need, and must have, rest and as far as possible made to forget their troubles; this is not always easily done as relatives and friends from their anxiety want to see them and cannot easily understand why this should be done. A careful examination should always be made to ascertain if any other diseased condition be present that could be the exciting cause of the mental condition and if so should be corrected if possible. The room should be of sufficient size and properly ventilated to insure sufficient wholesome air, not less than 100 cubic feet of space to one case; no more than one patient to each room of this size. Food should be nutritious and properly prepared for the needs of each case. Elimination by the bowels, skin and kidneys should always be brought as nearly as possible to the normal and kept so. During the exciting stage, rest in bed is of the greatest importance. Sleep must be secured if we expect these cases to improve. Chloral, hyocine and morphine and other drugs of this class should not be made to silence these cases as a means to avoid the work of inducing sleep by other more humane methods. The continual warm bath rarely if ever fails to induce sleep and has no after ill effects. A bath of 95 to 98 degrees continued for from thirty minutes to twelve or more hours rarely fails to induce sleep and may be repeated as often as required. The patient should be placed in a hammock or other means of support to make the patient comfortable; the body, except the head, should always be covered by the water, to prevent chilling of the exposed surface by rapid evaporation. The temperature of the water should be kept the same by changing the water by an overflow pipe, to let the water escape and the addition of fresh water at a temperature to maintain the temperature of the bath. Salt water is of some value but the temperature is the essential thing of importance. The first bath should be from fifteen minutes to one hour. In many cases this will be sufficient to control motor restlessness and produce a soothing influence on the state of anxiety. The bath may with propriety be continued for one or two days. A competent attendant should be present at all times during the bath, to carefully watch the case. By this means cases of mania and melancholia can be controlled without drugs or physical restraints. Bed sores do not trouble cases when cared for in this way. Baths of shorter duration can be utilized with great benefit in these cases until convalescence has been well established. After the acuteness of

the trouble is past, outdoor exercise is of great benefit and should be systematically carried out. The companionship of an intelligent attendant that will direct the mind of the patient away from the consideration of his delusions and cause them to be forgotten is of vital importance in the subsequent treatment of these cases. Patients should not be permitted to discuss their hobbies. This course of treatment is exacting on the time of the attendants and physician, but its results amply reward one for the care bestowed. After the bath the patient should be dried by the application of Turkish towels and without rubbing and the patient should always be placed in bed to sleep or rest for a number of hours. Massage is of great benefit in the farther treatment of these cases during the stage of convalescence. It may be used once or twice daily. Gymnastic exercise or the Swedish movements is also of great benefit in the subsequent care of these cases. Firmness on the part of the attendants is essential, but scolding or abuse of these cases should never be tolerated as it cannot be otherwise than harmful. Exercise should never be carried to the point of overtaking the strength. Sunshine for anemic cases is of the greatest importance and should be systematically carried out in the room for sunbath or to be much preferred in the open air when the weather will permit. Amusements in the convalescent stage is of the greatest importance; music, pool, billiards, bowling alley, lawn tennis and other means of diversion add greatly to the comfort of these cases and aid them to occupy their minds while being restored to their normal condition.

MENTAL TREATMENT.

A hopeful environment is of the greatest possible benefit in these cases. "As a man thinketh, so is he." This is eminently true of these cases. Attendants should learn to view the bright side of things and keep that thought constantly before their patients and should have sufficient time themselves to rest and be in a happy state of mind when on duty. During the exciting stage the patient should be kept in bed when not in the bath and should never be with other cases of mental derangement. Milk and eggs should be the principal diet during the exciting stage. Nutritive enemata may be used with advantage when other feeding cannot be carried out without too great a disturbance of the case. If the bowel be sensitive an opium suppository may be used half an hour before the rectal feeding.

ELECTRICITY.

Electricity is of doubtful value. In mild cases it may be used as a tonic but in the severer cases it is likely to do more harm than

good. As a suggestive measure it is at times valuable. Mercury in recent syphilitic cases is of decided value. Quinine for cases of malarial origin is of course indicated. Morphine 1-32 four times daily will decidedly benefit depressed manias. Hyoscine as a temporary remedy in excited mania is of value but should never be continued as it is capable of doing great harm. Suffonal and trional as sleep producers are probably the least objectionable remedies in cases where a remedy must be used to produce sleep. Normal saline solution subcutaneously in toxic cases every two or three days has been found of decided value. Tonics in cases where the general condition demands them are indicated in these diseases as in general medicine.

DISCUSSION.

Dr. Goddard:—Mr. Chairman, it seems to me that a paper of that kind should be discussed more by the general practitioner. The question, or the idea, brought forth by it is of great interest and importance. The early treatment is the thing in nine-tenths of the cases of mental trouble. In fact, there should be detention hospitals. As the doctor says, private institutions are not always run from philanthropic motives, although they ought to be. Of course, mine is run entirely on that line, but unfortunately, our number must necessarily be limited. There are a great number of cases that come under the physician's observation that really should never be sent to a state hospital at first. Not but that they get the proper treatment there; because I believe they are better equipped to carry out good treatment than anybody else; but, there is a certain stigma attached to going to a state institution, or to any institution that has the reputation of being an insane asylum. It is a bad name and should never have been used—any more than insanity. "When a person is insane, he is no longer himself and becomes a perfect devil. They are not themselves even to their own relatives. They are simply things to be kept away from." That is the bad idea that the laity at large have of mental trouble. Whereas, as a rule, they are the people that are the most kindly and easily managed of any disease, except in a very few cases. A detention hospital owned by the state would provide for a great mass of people that are unable to avail themselves of any care and are landed in jails or any old place, and if they have a chance to get well, they lose it. Drugs are used in a great many cases of brain trouble ("brain storms") that simply intensify the trouble already existing. If we had these detention hospitals, many cases would never come even to a trial. We have now a little better opportunity of handling people than dragging them before a public jury that often has more insane men on than are before it. They are senile demented that are hangers on of a court to try people who are accused of being insane. I second the paper in every respect. It was a good paper—well thought out and deserving of a good deal of attention. There is one little thing that the doctor (being or having been a preacher) has left for me to mention. That is, the use of alcohol. Alcohol, whiskey, milk punches, will do more to quiet patients of some classes than morphine, or the coal tar products. A good milk punch and a hot bath will do more good than

all the hypodermic injections you can shoot in. The coal-tar products meet with my entire disapproval. I came so near killing one woman with one of them at one time that I have never given it again. It kept me busy about three days to keep that woman living. There is a case now and then where coal-tar might help, but a hot bath will do just as well, possibly more good than any drug. When I give hyoscine, I give it; then, I quit; and, I quit oftener than I begin. A couple of years ago, I used to begin all the time; now, I am quitting all the time. By giving hyoscine in a case where you have anemia, you are adding fuel to the fire. Nine times out of ten you had better throw it out the window. It will do more good; but, if you do give it, shoot it in about 1-5 of a grain. You will be holding your breath for a while; but, if it does not put them to sleep, you had better not give any more. One thing that I object to in giving morphine is that they are apt to keep it up. They find out what it does for them and keep on. The one thing which I do not remember the doctor mentioning at all, is hydrate of chloral. It is one of the grandest things for mental trouble ever discovered. You get a more natural sleep than by the use of anything else and you get no bad results the next day.

Dr. Hughes:—I do not know what sort of juries the doctor is used to having patients tried before. In Wyandotte county these juries are good and have two physicians on them. I notice the doctor qualified his remark about the jury system somewhat. I should like to know if there is any different system in the state beside that in Wyandotte county.

Dr. Goddard:—The difference is this. Dr. Easton, assisted by Dr. Uhls and others, finally got a bill before the legislature, which was passed establishing a law which calls for the appointment of a medical commission to examine you or me. If we are reported insane, we have two doctors to examine us. You admit, I am sure that a jury system that allows the majority of the men on it to be men who know nothing of insanity whatever, is a system that is no good. The next best thing is this new law whereby a doctor is appointed as examiner. He is told to examine the case; and, if, after careful examination, he finds the man a fit subject to be restrained, he can be restrained in spite of himself.

Dr. Stemen:—I do not make any pretense to the treatment of nervous disease. Some years ago I used to spend my Saturdays in an insane asylum near Cincinnati. In cases of acute mania, especially if it was an anemic patient, their treatment there was ergot, bromide of sodium and bromide of zinc, not in very large doses, and sometimes hydrochloral. My observation was that they had very excellent results. They also used the hot bath. I want to second what the doctor said in regard to the coal-tar preparations. I think they are very objectionable and should not be used. I am glad that we have these private institutions—that we have a place where a patient can be sent without being sent at once to insane asylums. I think it would be a fine thing if we had a detention hospital where these patients could be sent at once and treated. I do not know how it is in this state; but sometimes, we have to hold our patients as long as three months before they can be sent to the asylum. They may be restrained in jail or in the almshouse. They have not room to admit them into the state institutions. This is a great mistake; and the need of a detention hospital is very apparent.

Dr. Uhls:—Dr. Goddard, if you will take the chair a moment, I should like to talk a little as this is along my line. If you have looked into the matter at all, you know that not more than a century ago it was impossible to arrest a man and put him in a place of detention, if he was not a criminal. There was no thought for a good many years of doing anything for the patient; nothing except to render the sane man more safe by confining the insane. But, as time goes by, you may readily see, that keeping along with the progress of medicine along other lines, as treatment is becoming more and more thought about, early treatment is receiving more attention. The doctor's paper calls to our minds one thing that should not be allowed to pass uncommented upon. I am aware, in talking to general practitioners that I am talking to men that have little care of the insane; because, it is going to be more and more the case that these people are to be taken in charge and sent to institutions. You do not get to prescribe clear through a case, and see what you can do. You will be asked your opinion; but, it will not be long until a patient will be committed to some institution, and no longer under your care; so, perhaps it is not very practical to talk about the treatment of the insane to you; but, there are some things to do in the early treatment of the insane. We have our different methods of doing it. I am convinced from the acquaintance I have with the physicians of the state that they are very glad to know and recognize a case of insanity as soon as possible. We are getting our cases sooner than we used to do. We are getting acute cases sooner than we used to do in our hospital. We get close to one case a day in our hospital, sometimes a little more; sometimes a little less. We are getting a chance to reach the patients in the early stages more than ever before. The doctors are thinking along these lines, and it is a good thing. If I get a patient where it can be stated that there were no evidences of insanity less than a week ago, I believe we can do something for him. I can go to work on that case with more confidence than on the other sort of case. A perusal of our biennial report will show that there is a little larger per cent of recoveries—not so large as we would like to have it by any means—but an increase. During the biennium, we received something like 700 patients, of which 38 per cent were sent out. Some will come back to us, but they were well. While a man is well, he is well. His trouble may recur, but for the time, he was well. I would urge this upon the profession: Get your patients under treatment at the earliest possible moment. Try something for them; but, do not hold them long. I believe it is your duty as a practitioner to try for a little time, for a few days. If you do not see that you are succeeding, you will be glad to have the patient placed where proper arrangements are made for his care. It seems to me that the doctor's paper covered the ground very well about taking care of these cases. You take a case of mania, and you may have another case very dissimilar. You have to treat each case to itself. The laity seem to have an idea that insanity is insanity. "My wife was insane and she got well in three months; and, if my neighbors' wife is insane, she ought to get well in three months," is their dictum. You doctors should instruct them along these lines and correct these things. One of the greatest troubles that we have to meet is that people think that "We will not send them to an institution as long as we can help it." There has been many false statements made regarding our institutions, public and private. Just now,

there is this erroneous idea abroad that we are not doing anything for these people, "running boarding houses," etc. The friend of advancement can help us to set that right. It is not true that there is nothing being done. It is unwise to have a sentiment prevail among the people that they will let it go as long as possible, send their friends there as a last resort—send them there if they have to do so. I appeal to the doctors to try to combat that idea for the reason that it is an injustice to the institutions to have them delay in sending a patient to them; and, it is an injustice to the patient. We are making our institutions more like homes and less like prisons; at least, we try to. We are not ahead of the rest of the world but, we believe that we are up with them. The treatment is much the same. However, we discuss these things among ourselves and go and visit one another's institutions. If a doctor is having better success than I am, I want to know why. The treatment is very much the same. The personal care is not just alike. Some spend more money in equipment than others do, but in a general way, the treatment is the same. What we ask for is early treatment, a reasonable amount of it by the home physician, then the cordial cooperation and a thorough explanation of cases when they come to us. Allow me to ask of the doctors present; When it comes your turn, as it does to each practitioner, make out the papers clearly. I would not want to disgust you with the statements that we receive. They are not definite. We cannot find out anything from them. One of the best things to know in early treatment is—What has been the condition in the past? What is the history of the case? Give us the clearest history that you can. We need it. It is of much value to the patient.

Dr. Boulton:—I want to emphasize the truth of the statement that in acute mania the patient falls into the general practitioner's hands first. The drugs used are very important. I want to ask the question if Dr. Glasscock has ever used chloraldehyde. Dr. Stemen suggested ergot. That is a new use for an old drug. You gentlemen who are not familiar with it, will find it very beneficial.

Dr. Uhls:—We use it freely.

Dr. Boulton:—This is not exactly discussing the question, but I want to say: When we have a man in charge of one of these institutions who has proven himself efficient, do not let political matters weigh in his retinal. It is injurious to the public and to the patients.

Dr. Brookhart:—I have a little experience along this line—seven cases in five years. Five of them have been sent to Osawatimie. In some homes, you can handle patients very well; in others, you cannot. If you have competent, sensible people to handle your patient, you can do well at home. If you have irritable attendants, you had better remove them as soon as possible.

Dr. Uhls:—Do not lie to these insane people. If you have a patient who is a little off, tell him so. Make it so plain he cannot help but understand it. So many times the relatives of an insane person or even the physician in attendance, deceives the insane person. He is told that he is coming to Kansas City. Patients will say to me: "Father lied to me." "My brother deceived me. I will never go home again, if I get well." Tell them they are insane. Make them believe it if you can. If not, you have done your duty.

Dr. Glasscock:—I am very much pleased with the discussion of this paper. As Dr. Uhls has stated, in the last law that was passed regarding this matter in the legislature, it was recommended, as far as possible to do so, to take this matter out of politics. I used to be in the legislature and did what I could in that direction. With the acutely insane, the essential thing to do for them is to treat them early. If you had a surgical case that needed operation, you would not wait. The same is true of general medicine. Every man engaged in general medicine does not keep a typhoid case walking around a while before he treats it. He puts it to bed. Our state institutions are doing good work. Our law is that you cannot put a man in as superintendent unless he has had two years experience in that line. We all know that the study of insanity—of mental derangements—is a life study. The first six months treatment of these cases is a critical time. The first year is critical. Unless a patient is treated properly and cured within two years, or I might say one year, the chance is practically passed. If we could put out of the minds of the people that because a man has something wrong with his brain, he must be held away from these institutions and only allowed to go there when he becomes too difficult to care for at home, we would accomplish a greater thing for humanity than we can estimate. We are progressing in our state as rapidly as anywhere else, I think. The superintendent of one of these institutions has been given direction to run the help as it should be done and to run the institution as it should be done. What we now need is that the money necessary for the proper care of these cases should not be limited. The expense is great. A great many cases become chronic and must stay there always. Money should be provided for the caring for these acute cases. Money should be no consideration. If they want to put in this line of treatment, or another line of treatment, money should not hold them back. If a man is cured in six months, the state is relieved of his care. The superintendent should be paid liberally. The question should not be: How much can you get a man for? But,—What can you get a man there for who is eminently qualified? And he should be kept there permanently regardless of the cost. Give them the money and permit them to care for these acute cases; then, you have made it possible for them to have facilities that they need. Chronic cases will stay; but, these acute cases can often and must be cured. Send your superintendents of these institutions, at the expense of the state, to visit every institution in this country and in the world, if necessary, that they may know from actual observation what is being done in every place. Every time there is an association of specialists these men should go to these meetings and have their expenses paid by the state. If the state employed a man to do surgery, they would not expect him to stay there on a little salary year after year; and, if he wanted to go any place, pay for it out of his own pocket. Furnish him the money to do anything on the face of the earth he wants to do in the interest of these acute cases; and have men, as we have in this state, who will use that money to the very best possible good. When an acute case is in a condition when it needs treatment, the best treatment on the face of the earth and the best equipment that can be furnished should be at their disposal. They should be unlimited in their ability to do anything they can do. The time is rapidly approaching when they will say of these acute cases: We have a case now. Let us not temporize with it. Do not have any stigma

attached to a man going to a state institution to be properly cared for. Make it possible for these men to be at every great meeting to get everything that they can get. Every time a man is cured and sent home, you take the expense of his care from the state; and, leave in our state men and women eminently competent to do the things that should be done. Now, whether we send our cases to private or state institutions, let us be broad minded as to salaries. If it is necessary for us to spend \$50,000.00 a year, let us spend it; and every \$50,000.00 that you spend will be returned ten-fold in the amount of benefit that you rendered the community and the citizens of the state. That is the great lesson that I desire to impress: By giving these men in these prominent positions the opportunity to do whatever they desire, you will render a benefit you could not render in any other way.

TOXEMIA FROM UNDRAWN POULTRY.

The above is the title of an editorial in the New York State Journal of Medicine of April, 1907, p. 157. Dr. R. L. Crockett, the city bacteriologist of Oneida, N. Y., made cultures from drawn and undrawn poultry, with the following results: From 100 undrawn kept at a temperature of 40 degrees, which is the usual house refrigerator temperature, cultures made from the abdominal wall showed intestinal bacteria 4 days after killing, and in 4.5 days in the muscles of the breast and legs; at a temperature of 70 degrees the intestinal bacteria were found within 18 hours in the abdominal wall, and 27 hours in the muscles of breast and legs.

From drawn poultry, at 40 degrees, cultures made up to the 28th day, and at 70 degrees up to the 14th day, failed to show the presence of intestinal bacteria.

The colon bacillus was found in every case examined of the first series; the streptococcus pyogenes in 65 per cent, staphylococcus pyogenes aureus in 20 per cent., and proteus vulgaris in 6 per cent.

Accepting these results as correct, the conclusion is plain that poultry should be drawn before placing in cold storage or offered for sale.

The American Public Health Association will hold its thirty-fifth annual meeting September 30 to October 4, at Atlantic City, N. J.

The so-called "quick-cure" of gonorrhoea is the most dangerous practice known, as it is very liable to lead to the development of stricture.

Forcible divulsions of a stricture is both barbarous and inefficient. Gradual dilatation is more satisfactory to the patient but does not result in good that is permanent.

HEPATIC ABSCESS.

By T. E. SCHWARZ, M. D., Clay Center, Kansas.

In 1579, Ambrose Pare, the greatest surgeon of his day, wrote a voluminous work on surgery, and in it he says: "As God is my witness and all good men know, I have labored fifty years with all care and pains in the illustration and amplification of surgery, and that I have so certainly touched the work whereat I aimed, that antiquity may seem to have nothing wherein it may exceed us. Except for the glory of invention, posterity has nothing left, but the hope of adding some few things." Now, I believe we have added some few things since the year 1579. And if it is true that we see the future by viewing the past, we can expect equally brilliant discoveries in the days that are to come. Even in my time, appendicitis has been brought from obscurity to light, and our efforts at a cure are now intelligent and effective. With the frequent opening of the abdominal cavity our knowledge of abscess of the liver will be equally advanced. We will find that it is NOT a tropical disease. We will find that with the acquisition of the Philippines, the opening of the Panama canal, Cuban annexation, and the increased southern traffic, that this disease has broken down its southern barriers and refuses to be held by any geographical limitations. And it is one of the objects of this paper to establish this fact.

Do you all remember how a few years ago, the grippe was considered a disease peculiar to the densely populated regions of Russia? How it broke its bonds and went on an excursion of destruction? How the news of its coming was flashed on ahead and like a tidal wave from the sea it came rolling on and on with relentless fury, gaining momentum as it came, until finally it dashed itself upon our shores and swept over the land; then frothing with the ruin it had wrought and gorged with the many lives it took, it again receded to sea. It no longer makes an organized attack, it is now always with us.

Further—With the improved railroad facilities, where it is possible in two days to leave a snow-clad country, in the midst of a grim winter, where the Storm King reigns supreme, and enter a

land of sunshine and flowers. The snow-blinded eyes of the traveler, today, are greeted by green fields and meadows tomorrow. Today, his ears are filled with the shriek of the north winds' icy blasts, as it whips the flurries of snow into heaps; to-morrow, the mellow lowing of cattle, the lazy droning of the bee as it flits from flower to flower, accompanied by the sweet carols of the song birds. What a miracle! To-day, a man in Florida may become inoculated with the parasites peculiar to a tropical country and tomorrow ring your door-bell! How true in medicine is that national expression "There is no North, there is no South, there is no East, and there is no West."

And finally—the intense virulence and the increased frequency of intestinal grippe, typhoid fever, and appendicular inflammations will all help to place abscess of the liver on its real pinnacle of importance.

Literature on Hepatic Abscess is peculiarly scarce and in the preparation of this paper, I have drawn freely from all journals, papers, text books and friends.. With this acknowledgment, I will proceed.

CLASSIFICATION.

Here at the very start, lies the cause of a great deal of confusion and strife. I have reflected over the various classifications of hepatic abscess and have found the classification of Dr. Cantlie, surgeon to the Alice Memorial Hospital at Hong Kong, China, to be the most rational, and least confusing of all. He utterly disregards the terms tropical abscess, large solitary abscess, pyemic abscess, etc., and classifies them according to their location, thus—(1), Supra-Hepatic, when the primary collection of pus is situated between the layers of the coronary ligament. (2), Intra-Hepatic, when the collection of pus is in the substance of the liver, and (3), Sub-Hepatic, when the liver itself forms the roof of the abscess.

An abscess is an abscess, no matter where placed. It has the same general history and is only slightly modified by the peculiarities of the tissues involved and the kind of pyogenic bacteria present. In hepatic abscess, besides all those caused by the pus-producers, we must consider an extra one—Amebic abscess. It is produced by the activity of the *Entamoeba Dysenterie*;—a protoplasmic micro-organism, circular in form and fifteen to twenty-five microns in diameter. They were first described by Losch in 1875, who gave them collectively the name, *Ameoba Coli*; but it was found that this term covered also a harmless, as well as a pathogenic variety, and hence Schaudin divided them into *Entamoeba Histolytica*—the harmless

variety, and the Entamoeba Dysentery, the pathogenic. The life history of the Entamoeba is unknown. They are not very resistant to injurious influences and are readily killed by weak solutions of disinfectants. A solution of quinine, one to three hundred instantly arrests their motility and they will die within a half-hour if allowed to cool to the temperature of the room. Parenthetically, let me say, that with an organism so feebly resistant to remedial agents, we would expect more brilliant results by the injection method of curing dysentery. But when we bear in mind that only a small portion of the colon comes in contact with the injection remedies, and while the superficial layers of Ameoba are destroyed, those myriads of them lying in the sub-mucous coat are not affected. This little point accounts for the persistency of ameobic dysentery, and the frequency of its relapses. One original infection can thus continue the disease through a life-time.

The recognized method of infection is by the gastro-intestinal tract. Next to the intestines, the liver is the most frequent organ affected. They are thought to produce abscess of the liver by blocking up of a venous radical and then, by the local effect of the toxins they secrete, produce pus. This pus is sterile in about fifty per cent of the cases. Its appearance is also characteristic. It is a semi-fluid, yellowish red, or chocolate colored mass. One author describes it as a "tomato soup fluid." It contains shreds of Necrotic tissue, blood, leucocytes and ameobae. It is "tomato soup" in color when the blood predominates, and chocolate colored when the shreds of liver substance are abundant. The favorite location of such an abscess is in the right lobe, especially near, or at the dome; i. e., supra-hepatic and intra-hepatic.

It is well known that the ameobae are the most frequent cause of this disease in the tropics, but that it may also be found from the most northern borders of the arid steppes of Siberia to the jungles of darkest Africa, ought to be equally well known. And in the near future, this one fact will be borne home to us, more and more forcibly.

Another very important etiological factor is emolic and ascending pylephlebitis. Any suppurative process occurring in the area drained by the superior and inferior mesenteric veins, may produce a hepatic abscess in this manner,—an infected embolus originating in some suppurative process, obtains entrance in one of the mesenteric veins. Its circumference is much smaller than the caliber of the vein, and it is therefore readily carried upward in the blood stream, through the portal vein on into the liver. Here the veins

divide and sub-divide, again and again, until finally the embolus becomes lodged in a vessel whose caliber is smaller than its bulk. The nutrition of a wedged section is interrupted, a venous stasis occurs—the best culture media for pathogenic bacteria—and an abscess results. And incidentally that is why hepatic abscesses are primarily of a wedge shape. Reflect a moment; how many conditions may give rise to such an embolus. Ischio Rectal abscess, Hemorrhoids, Ulcerations of the rectum, dysentery, appendicitis, typhoid fever, gastro-enteritis, etc., you can continue the list at your leisure.

Remember an apparently insignificant suppurative process may be the parent of an enormous abscess. Let me recite you a case occurring in Dr. Jabez N. Jackson's practice, which I believe has a very important lesson for us, and especially for that man who favors a "resting-on his oar" attitude in appendicitis.

"Mr. McC., age 12, was taken down with a slight pain and tenderness in the region of the appendix with a moderate elevation of the temperature, about 100. While possessing no acute or alarming symptoms, the boy seemed to be rather unusually depressed and I was called to see him after he had been sick about five days. At this examination, there was found no rigidity of the right rectus, no palpable tumor, and was in general, negative except for a slight deep-seated tenderness over the region of the appendix. I MADE A PROBABLE DIAGNOSIS OF MILD CATARRHAL APPENDICITIS and advised operation, but did not urge it, as the condition was not apparently of any extreme severity. My advise was not accepted, and I saw nothing more of the patient for about a week, when he was finally brought into the hospital. He continued to have a constant but moderate temperature from which there was more than usual feeling of depression and a pulse running from 100 to 120. On examination at this time I was unable to find any tenderness over the appendix, even on deep palpation and abandoned therefore my diagnosis of appendicitis. The case having been decided to be non-surgical, passed out of my observation and at various times was seen by three of the best internists of Kansas City, one of whom made a diagnosis of MALARIA, one of TYPHOID, and a third made a diagnosis of INTESTINAL TUBERCULOSIS. The subsequent history is that the boy had a continuous fever running about normal to 101 and later 103, with a rather rapid pulse, general evidences of physical prostration, and in the later part of the disease, rather frequent indistinct rigors accompanied by profuse sweats. The patient died, apparently from exhaustion, after an illness of

about a month. I requested an opportunity to make a postmortem, desiring particularly to ascertain what could have been the condition in the neighborhood of the appendix which at first led me to make the diagnosis of appendicitis. On opening the abdomen, the liver was found to be enormously enlarged, extending down below the umbilicus, but apparently otherwise natural to the eye. There was no evident signs of peritonitis or adhesions. In lifting the right lobe of the liver for deep inspection, the liver ruptured, discharging probably a quart of pus. The same thing happened on handling the left lobe. In other words, there were two large abscesses, one in either lobe, each containing almost a quart of pus. Unfortunately no microscopic examination was made of this pus. When I proceeded to examine the neighborhood of the appendix, I found that there was no appendix intra peritoneally. After dissecting up the caecum from its outer side, we found that the appendix had been retro-peritoneal, turning up behind the caecum. We found that it had ruptured about an inch from its base, and that the perforation had occurred into the substance of the psoas muscle. This muscle had been destroyed entirely and resembled very much the appearance of this structure, after the students had dissected out the lumbar plexus of nerves in the dissecting room. Clearly, therefore, this had originally been a case of retro-peritoneal appendicitis, perforation of the sheath of the psoas and secondary involvement of the liver from septic emboli. The striking symptoms were marked prostration, rather continued depression, frequent indistinct rigors and profuse sweats."

What is the course of a hepatic abscess, or what will such an abscess do if not interfered with surgically? To those physicians who practice "In God we trust," waiting for the abscess to burst; to them let me say, their faith is well founded. It will rupture; especially, if the patient lives long enough. For the Lord knows, his life will be plenty short enough after it does rupture! **WHERE WILL THEY RUPTURE?** Let us look at this chart of cases; but before analyzing it, let me again parenthetically say that I earnestly believe EVERY abscess of the liver, no matter where located, or how caused, should be evacuated.

Observers	Cases of Liver Abscess	Cases of Rupture	Pericardium	Pleura	Lung	Colon	Stomach	Bile Ducts	Vena Cava	Kidney	Lumbar Region
Waring	300	68	14	28	15	2	1	1	4	2	2
Dutroulau	66	25	2	10	7	1	1	.....	.....	.....	4
Romo	162	54	11	17	14	3	6	2	.....	.....	.....
Haspel	25	6	4	2	.....	.....	.....	.....	.....	.....	.....
Cambay	10	3	.....	2	.....	.....	.....	.....	.....	.....	.....
Howard	6	5	5	.....	.....	.....	.....	.....	.....	.....	.....
Craig	24	7	2	5	.....	.....	.....	.....	.....	.....	.....
Total	593	168	36	64	36	6	8	3	4	2	6

—From "International Clinics," Vol. IV, Series XIV.

What a frightful mortality must have occurred! If these cases, represented here, could rise up and give their testimony, do you suppose they would advocate a "waiting policy?" You will notice by this chart that 100 out of 168 ruptured into the pleura and lungs. To the man who "waits," let me say, that when the abscess does rupture, you have not accomplished anything. You have taken a step backwards. You now have an abscess of the liver, a septic pleurisy, an abscess of the lung, with great destruction of tissue, where before you only had an abscess of the liver. To further show you the ruins, let me quote from a case report of Dr. James Edwin Thompson, Professor of Surgery, University of Texas. A patient was brought to him after a hepatic abscess had ruptured into the lung. He also found that two ribs were black and necrotic. He says: "It was then thought advisable to remove the necrotic ribs and pack the abscess cavity with gauze. This was done, and a cavity was found large enough to hold two fists. An opening was seen through the diaphragm, leading into a ragged cavity in the liver as large as an orange. A ragged hole led into the right lung, which was partly destroyed and formed part of the wall of the abscess cavity. It was one of the most horrible chasms I have ever seen! Each day it was carefully irrigated and packed with iodoform gauze. It held almost two yards of gauze. As is often observed in these cases, no attempt at repair was seen; the patient was too exhausted to recover, and he died in two weeks." If THAT patient could be here amongst us this evening, do you suppose he would advocate a "waiting policy?"

SYMPTOMS.

Abscess of the liver is never a primary affection. Taking the history of a case, you will always find a preliminary disease—a fore-runner. Do not overlook this preliminary disease, no matter how apparently insignificant it may appear. Remember what an enormous abscess occurred in Dr. Jackson's case, following an apparently insignificant appendicular inflammation. Be especially alert in intestinal grippe. This point was beautifully illustrated in my last case. Of course, a dysentery is the official usher of hepatic abscess, and in the management of a case of dysentery, it would be a good rule to make a daily examination of the liver.

INSPECTION.

The patient has the appearance of being gravely ill; a peculiar pinched face and melancholy look. He has lost interest in the game of life, and his discouragement is plainly visible. Remember jaundice is not a cardinal symptom, and is only seen when a large bulging abscess presses on the biliary ducts, and thus mechanically produces an occlusion. A sallow, yellowish tinge is seen, and is due to anemia. Standing at the head of the patient, viewing his naked body, you will notice a marked asymetry of the two hypochondriæ. The respiratory movements of the right side are restricted. A general fullness of the liver region with a widening of the intercostal spaces, especially when the abscess is in the right lobe near the surface, may even amount to quite a bulging. Epigastric veins stand out as distinct blue lines. By carefully inspecting the lower costal zone, you will find small spots of oedema, about the size of a penny. These mark the site of the abscess, and are the places of choice, for inserting an exploratory needle. No rigidity of the abdominal muscles is seen until the abscess approaches the surface. All these symptoms may be verified by palpation and percussion, (And before leaving palpation, let me remind you that you can distinguish the liver from all the other abdominal organs by its movements during deep respiration.)

URINALYSIS shows at first an increase of urea, due to the irritation of the hepatic cells, but as the abscess flourishes, increasing in volume, pressing on those hepatic cells at a distance, and destroying those within reach, a deadening effect is produced, and a great reduction in the amount of urea is found. Namely a hypoazoturia. Yet a little farther, the elaborate chemical equation of digestion is thereby interrupted, unnatural end-products are being formed, and, in the absorption of which, I believe, we can find the cause of the patient's melancholic and cloudy mind.

SUBJECTIVE SYMPTOMS.

A feeling of malaise is often present for weeks and months before definite symptoms show themselves. The temperature takes a septic course and is unreliable; but an elevation is persistent; generally higher at night. Profuse drenching sweats are characteristic, occurring during sleep, no matter if it is day or night. Blood count shows a marked leucocytosis.

THE NERVOUS SYMPTOMS.

A nervous, irritative cough, called by some the *tussis hepatica*:—the cough of the liver. The melancholic and hypochondriacal mind, I have before explained. A complete loss of appetite, amounting to a revulsion at the very sight of food.

PAIN may occur in any of three distinct places, (1), in the region of the liver, (2), over the shoulder blades, (3), at the point of the acromiun processes. Let us take them up, one at a time, they are important and our time will be well spent.

PAIN IN THE REGION OF THE LIVER occurs in the great majority of cases. This pain varies with the stages of the disease.

When the abscess is deep in the substance of the liver it is of a dull, aching, grinding character—it is the groan of the wounded liver cells; but as the abscess approaches the surface and the peritoneal coats become inflamed and these raw surfaces rub at each respiratory movement a sharp, stabbing, lancinating pleurisy pain is experienced. (And here lies the cause of restrictive respiratory movement.) On pressure, all these pains are intensified.

PAIN OVER THE SHOULDER BLADES, is next in frequency, and is of a dull, agonizing “sickening” character, often intermittent. The patient vainly tries to find a comfortable position. This may be present when no other hepatic symptoms are found. Pain in this region should be to you a guide post, directing your search toward the liver. By obeying this injunction, you will never go far astray.

PAIN OVER THE ACROMION PROCESS, when present is pathognomonic. On the right side in abscess of the right lobe; on the left side in abscess of the left lobe. Unfortunately this symptom is not always present. Reflected liver pains may be anatomically explained, by them passing up the phrenic nerve to the cervical plexus and there the third and fourth cervical nerves carrying them to the shoulder blades and acromiun regions respectively. A trocar plunged in one of the afore mentioned spots of oedema will usually strike pus and if the trocar is left in place, it will act as an admirable guide during the operation. Remember there is no car-

dinal symptom of hepatic abscess. Collectively, they are:—History of a previous disease, especially one occurring in the area drained by the superior and inferior mesenteric veins, a general feeling of malaise, early and profound prostration, persistent elevation of temperature, profuse drenching sweats occurring during sleep, a yellow, sallow appearance of the skin, pain in the hepatic region, over the shoulder blades, over the acromiun process, or all three places, enlargement of the liver, widening of the intercostal spaces, spots of oedema over the lower costal zone and a leucocytosis,—spells abscess of the liver—a non-tropical disease, with nothing but a surgical treatment.

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Severance, Kans., August 15, 1909.

Editor Journal of the Kansas Medical Society.

Dear Sir:—I have been interested in reading the paper of Dr. Biddle in the July number of the Journal. I consider that no apology is needed for the introduction or discussion of any subject pertaining to obstetrics. Obstetrics is the specialty of the general practitioner in the country. However little he may know of other specialties he must learn by study and practice, to become a good accoucheur. In regard to the subject of puerperal infection I am unable to agree with Dr. Biddle in his wholesale condemnation of the general medical profession as being criminally negligent and “responsible for a large per cent of deaths from puerperal infection.” I do not believe that any intelligent physician ever infects a puerperal woman with “dirty hands” or “dirty instruments.” I am acquainted with some young men who I think may make unnecessary use of instruments, but I believe all take great care in making them aseptically before using them. I am not acquainted with any physician who makes a “grand stand play of asepsis.” I do not know any who use a “dirty soap dish or soap.” The family wash pan is sometimes used, but it can be made clean by hot antiseptic solutions. The writer, however, carries with him a graniteware pan which is used for no other purpose. I do not know of any physician who continues to wear, without cleaning, a suit of clothing which he has worn while attending cases of diphtheria or scarlet fever. If the doctor cannot clean his own suit, his wife generally can, and a small quantity of solution of formaldehyde and some potassium permanganate is all that is needed for fumigation. Even if a suit is a year old, it need not be septic.

It is true that in country practice we cannot obtain ideal condi-

tions such as can be found in hospitals. It is also true that septic cases sometimes occur in hospitals. In my own practice extending over a period of thirty-two years, the cases of septic puerperal fever that I have seen have usually occurred in women who have been confined without the attendance of a physician or who have been infected prior to the beginning of labor. Of the latter I wish to refer to two cases. The first case I saw two hours after the child was born. The labor seemed to have been short and normal in every respect, but the woman already had considerable fever and rapidly developed a typical case of pyaemia. The child was also infected and developed numerous abscesses over the surface of the body. It is clear that this woman must have become infected prior to the beginning of labor, and from what I could learn of her previous history the source of the infection must have been a diseased tube on the right side. In other words, it was a case of auto-infection. The second case was one of pyaemia also, with formation of deep abscesses. The labor was normal but the mother developed a high temperature within two hours. She finally recovered after a severe illness of three weeks duration. The source of infection was doubtless a horse with a suppurating sore. The husband of the woman was treating the horse and the transmission was probably by him via the family wash pan, or perhaps still more directly. I consider the husband to be frequently the most dangerous source of trouble not excepting the old granny nurse, who, though ignorant, does generally clean up a little on such occasions. The sources of infection are numerous and no physician should needlessly criticise another who happens to have a case of septic fever in his practice. Let us remember that we live in glass houses and must not throw stones. In regard to the instruction of women in the country who go about the neighborhood nursing; I think the most of them are from Missouri and must be shown. Printed matter will rarely reach them. I am of the opinion that the people in general are becoming better informed in regard to proper sanitary conditions. We have much less diphtheria and typhoid fever than we had twenty years ago.

Every educated physician is a missionary who teaches the people, by precept and example, how to live. The profession is doing more for the real benefit of mankind than are the members of any other calling. And the country physician is filling his place as faithfully as is the worker in the laboratory or hospital. Let us be optimists not pessimists.

S. H. BLAKELY.

THE JOURNAL OF THE KANSAS MEDICAL SOCIETY.

Entered at the Postoffice at Columbus, Kansas, as Second Class Matter.

CHAS. S. HUFFMAN, EDITOR
J. E. SAWTELL, }
GEO. H. HOXIE, } ASSOCIATE EDITORS

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State Meetings to Be Held in the Fall. Dr. J. N. McCormack, chairman of committee on organization, in his report to the House of Delegates of the A. M. A., calls attention to the advisability of holding the state meetings in the fall. This is a matter that should be considered by our state society, and we hope to see the matter discussed at our next meeting.

The American Medical Association meets immediately after the state meeting, and many who would like to attend both meetings find it impossible to do so by reason of the time of meeting being so near together. If the state meeting could be held in the fall many more would be able to attend both meetings. Below is a paragraph from Dr. McCormack's report:

"For the reason set forth, and for others still more important, it is again urged that all the state associations which have not yet done so, seriously consider the advantages to be gained by holding their meetings in the fall, as nearly as may be, midway between the meetings of this association. A number of state associations have already acted favorably on this suggestion and the advantages of the arrangement are evident. With the state and national meetings coming within a few weeks of each other, as is often unavoidable when both are held in the spring, many of our best members are forced to miss both of them. In addition, and probably more important, half of the delegates from such states begin active service at once within the time for such inquiry and study as would make them most useful to their constituents and to the cause of organization "

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Examination Fee Five Dollars. The Mutual Life Insurance Company of New York has sent notices to all their examiners that hereafter the examination fee will be five dollars. The Equitable Assurance has also raised the examination fee to five dollars. This is in line with other conditions in this country, to get the best talent, fair remuneration must be paid for it.

SOCIETY NEWS.

Topeka, Kans., Aug. 13, 1907. Editor Journal:—There was a good attendance of Topeka physicians at the regular monthly meeting of the Shawnee County Medical Society held Aug. 5th. Dr. A. B. Jeffrey read a paper on Puerperal Infection. He translated from Hippocrates a detailed account of how the wife of Diomedes, the King, became septic after labor and died, causing her attendant court physicians great worry.

Applications for membership were received from Dr. M. A. Floersch and Dr. W. W. Caldwell both of Topeka. J. B. TOWER,
Secretary.

Kansas City, Mo., June 29, 1907.

Editor Journal:—For the Committee on Scientific work to act with yourself I have appointed Dr. O. P. Davis, of Topeka, and Dr. M. T. Sudler, of Lawrence.

For the Committee on Public Policy and Legislation I have appointed Dr. C. C. Goddard, of Leavenworth, Dr. M. C. Porter, of Clay Center, and Dr. J. F. Gsell, of Wichita.

Very truly yours, J. E. SAWTELL.

Editor Journal: On September 2nd the Shawnee Medical Society had a very good meeting. There was a large attendance. Two interesting papers were presented, one by Dr. Sara E. Greenfield on the "Negri Bodies" found in hydrophobia. The doctor showed these bodies under the microscope, presenting several slides, prepared from a dog which recently died of hydrophobia here in Topeka. The other paper was by Dr. John A. Crabb on "Practical Laboratory Aids," in which he took up only the everyday practical tests which every conscientious physician ought to make, and explained the simplest methods of performing them. Both were valuable papers, and they were freely discussed. Two new members were taken into the society, Dr. M. A. Floersch and Dr. W. W. Caldwell, both of Topeka. The Kansas Medical College tendered the use of their new lecture rooms and accessories to the society as a permanent meeting place, and their offer was accepted.

JOHN B. TOWER, Secretary.

Society Meeting.

The Northeast District Medical Society will meet at Topeka, October 10, 1907. This society is made up of 18 counties of Northeastern Kansas. A good program has been prepared, and a large attendance is expected.

Mississippi Valley Medical Association.

The thirty-third annual meeting of the Mississippi Valley Medical Association will be held at Columbus, O., Oct. 8, 9., and 10, 1907, under the presidency of Dr. H. Horace Grant, of Louisville, Ky., The orator in Medicine will be Dr. Geo. F. Butler, of Chicago, Ill., and the orator in Surgery Dr. Frank D. Smythe, of Memphis, Tenn.

The Association is doing commendable work in furthering the cause of medical research, by offering a prize of \$100 for the best original essay upon some medical or surgical topic. The committee of the Association to decide upon this contest is composed of Drs. Hugh T. Patrick of Chicago, C. H. Hughes of St. Louis, and A. H. Cordier of Kansas City.

Preparations are being made on an extensive scale for the entertainment of members and guests by the profession of Columbus, with the following Committee of Arrangements: Chairman, F. F. Lawrence; Secretary, Chas. J. Shepard; Treasurer, William E. Davis; Committee Ways and Means, J. W. Clemmer; Entertainment, J. U. Barnhill; Transportation, W. J. Means; Exhibits, W. Means; Reception, J. H. J. Upham; Press and Information, Frank Winders; Halls and Meetings, Earl Gilliam; Badges, J. E. Brown; Registration, Wells Teachnor; Ladies, Mrs. W. D. Hamilton.

The following is a list of papers which have been offered up to August 15th, and there are many promises for papers from other well known men in the Valley:

I. A. Abt, Chicago, Ill., Urinary Infections in Children.

Chas. J. Aldrich, Cleveland, O., The Psychoses of Pneumonia.

M. A. Austin, Anderson, Ind., The Kidney Surgically Considered.

Carl Beck, Chicago, Ill., Gastric Ulcer.

M. R. Burkner, Chicago, Ill., When Should Gastric Ulcer be Treated Surgically?

A. D. Barr, Jersey City, N. J., The Relation of Metabolic Ferments to Metabolism; Especially in Diabetes, Mellitus and Tuberculosis.

Chas. E. Barnett, Ft. Wayne, Ind., Vesico-Urethro-Vaginal Fistula.

J. E. Cannady, Hansford, W. Va., Treatment of Pus Tubes.

T. D. Crothers, Hartford, Conn., The Relation of the Doctor to the Alcoholic Problem.

Geo. B. Evans, Dayton, O., Local Anesthesia versus General in Ano-Rectal Surgery.

Geo. W. Finley, Brazil, Ind., Gastro-Enteritis.

Frank W. Gavin, Canton, O., Medical Inspection of Public Schools.

A. E. Halstead, Chicago, Ill., Cancer of the Typhoid Gland.

M. L. Heidingsfeld, Cincinnati, O., Some Clinical and Differential Features of Syphilis, as Demonstrated from Lantern Slides and Wax Models.

Earl Harlan, Cincinnati, O., The Frequent Inter-dependence of Dislocated Kidney, Gall-Bladder Trouble and Appendicitis.

Marc Ray Hughes, St. Louis, Mo., Anomalies of the Stigmata of Degeneracy.

G. Frank Lydston, Chicago, Ill., Plastic Work on the Urethra—A New Operation.

Harold A. Miller Pittsburg Pa. Pregnancy Complicated by Pulmonary Tuberculosis

J. B. Murphy, Chicago, Ill., Pleuritis and Its Surgical Aspects.

C. M. Nicholson, St. Louis, Mo., Primary Abdominal Pregnancy.

Curran Pope, Louisville, Ky., The Value of Physio-Therapeutic Methods in Chronic Diseases.

D. C. Peyton, Jeffersonville, Ind., Tuberculosis of the Bones of the Feet, with its Treatment.

Chas. A. L. Reed, Cincinnati, O., Important but Frequently Disregarded Clinical Phases of Movable Kidney

Merrill B. Ricketts, Cincinnati, O., Treatment of Stump in Appendectomy.

H. H. Roberts, Lexington, Ky., Gastric Ulcer.

Albert E. Steine, Indianapolis, Ind., Radical and Palliative Operations for Cerebral Hemorrhage.

Mark D. Stevenson, Akron, O., Purulent Conjunctivitis in Infants and Adults.

Geo. P. Sprague, Lexington, Ky., Drug Addictions.

Geo. B. Twitchell, Cincinnati, O., Internal Rotation and Lacerations of the Perineum.

Frank B. Walker, Detroit, Mich., Treatment of Inguinal Hernia in Children.

Edwin Walker, Evansville, Ind., What We Cannot do with Purgatives.

A. U. Williams, Hot Springs, Ark., Some Cases of Re-infection with Syphilis.

C. E. Briggs, Cleveland, O., Volvulus of the Entire Mesentery of the Small Intestine, with Report of Case.

Sanger Brown, Chicago, Ill., Medicolegal Notes

J. Rawson Pennington, Chicago, Ill., The Sigmoidal Factor in Pelvic Diseases.

Bernard Asman, Louisville, Ky., Cancer of the Rectum.

Robt C. M. Lewis, Marion, O., Neroses of the Bladder.

Hugh F. Lorimer, Chillicothe, O., The Early Diagnosis of Gall-Stones.

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Meeting of the American Medical Society. The House of Delegates of the American Medical Association met at Atlantic City on Monday, June 3rd, and was presided over by the retiring president, Dr. W. J. Mayo. Two sessions of the house were held on Monday, one on Tuesday, and two on Thursday. Dr. Joseph D. Bryant, president elect was installed at the general session on Tuesday morning.

The present membership of the Association as shown by the

General Secretary's report was 27,515, an increase during the year of 3,879 members.

The average weekly circulation of the Journal for 1906 was 45,479 copies. A table was given showing the number of physicians in each state and the number and percentage receiving the Journal. According to this report there is only one state in the union having as many physicians as Kansas and a greater per cent. receiving the Journal and that is Wisconsin, which has a lead of 2.4 per cent. According to the number of physicians in each state, Kansas made the largest gain in the mailing list of the Journal for 1906.

The report of the council on Medical Education recommended that all medical schools be annually inspected for the next three years and it urged the association to ask state licensing boards to make annual inspection of all medical schools in their states and to refuse to license undergraduates. That recognition be refused night schools or schools conducted solely for profit. The annual conference held by the council which should be composed of delegates from each state licensing board and from each state medical society was endorsed.

The report of the committee on the establishment of the board of public instruction on medical subjects recommended the establishment of such board, which should endeavor to educate the public through the press, through distribution of pamphlets, through public lectures and circular letters.

The reference committee on reports of officers made the following report with reference to fees for life insurance:

We endorse the report of the insurance committee and believe that a minimum fee of five dollars for life insurance examinations is just and fair, and we deprecate the organized efforts of certain companies to compel the acceptance of a lesser fee. While it would seem desirable for county societies to take cognizance of this matter, we further deprecate the exercise of any harsh or coercive measures directed against individual members. We also agree with the view that present differences will eventually be amicably adjusted.

The council on pharmacy and chemistry offered the following resolutions:

Resolved, That this Association most earnestly requests all medical journals to refuse to aid in promoting the sale of preparations which have not been approved by the council, by refusing advertising space to such preparations; and be it further

Resolved, That we most earnestly request the moral and financial support of our members for those medical journals, whether privately owned or controlled by medical organizations which disregard commercialism and stand firm for honesty and right dealing, thus sustaining the council in its greatest work for the medical profession.

Kansas was entitled to a representation of these members in the house of delegates this year, all of whom were present, viz:—Dr. C. E. Bowers, of Wichita; Dr. Alkire, of Topeka, and Dr. Sawtell, of Kansas City.

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Medical Association of the Southwest.

We are in receipt of the program of the Medical Association of the Southwest, which will meet at Hot Springs, Ark., October 8-10, 1907.

The railroads have promised a rate of one and one-third of the regular fare, on the certificate plan. Every person in attendance should secure a certificate from the railroad agent when purchasing their ticket.

This association promises to become one of the most important of the medical societies held in this country. It includes a group of states, occupying the richest portion of the Mississippi Valley. The meeting is divided into three sections, each presenting an interesting program.

PROGRAM.

SECTION ON GENERAL MEDICINE

SECTION OFFICERS.

Chairman, Dr. S. C. James, Kansas City, Mo.

Vice Chairman, Dr. F. B. Young, Springdale, Ark.

Secretary, Dr. C. C. Goddard, Leavenworth, Kans.

- 1 Dr. Howard Hill..... Kansas City, Mo.
"Gastric Ulcer"
- 2 Dr. Flavel B. Tiffany..... Kansas City, Mo.
"An illustrated lecture on some of the more common diseases of the eye."
- 3 Dr. F. B. Young..... Springdale, Ark.
"Polycystic Degeneration of the Kidneys," with report of a case.
- 4 Dr. Edwin B. Kenner..... Galveston, Tex.
"A Piece of Chewing Gum as a Nucleus for a Vesical Calculi."
- 5 Dr. L O Green.... Pea Ridge, Ark.
"Gastro-Enteric Intoxication"

- 6 Dr S S Glasscock.....Kansas City, Kans
"Divorces"
- 7 Dr F E Potter.....St Joseph, Mo
"Cholycystitis"
- 8 Dr J M Taylor.....Ft Smith, Ark
"Tuberculosis of the Kidney"
- 9 Dr W H Stouffer.....St Louis, Mo
"Sigmoiditis"

- 1 Dr John Puntton.....Kansas City, Mo
"The failure of Law and Lawyers to Cope with Modern Medico-legal
Exigencies and its Remedy"
- 2 Dr Jerome D Potts.....St Louis, Mo
"Rectal Diseases as Considered by the General Practitioner"
- 3 Dr A K West.....Oklahoma. City Okla
"The General Practitioner and the Specialist: The Sphere of each and
their Relationship"
- 4 Dr B F Collins.....Needmore, I T
"Hysteria"
- 5 Dr B L Hale.....Neal, Kans
"Toxaemia of Pregnancy"
- 6 Dr J W Duke.....Guthrie, Okla
"Periodical Insanity"
- 7 Dr Thos J Beatty.....Kansas City, Mo
"Disturbances of Various Kinds Coincident with the Menopause"
- 8 Dr R D Moore.....Omaha, Tex
"Puerperal Eclampsia"
- 9 Dr W R Russell.....Texhoma, Okla
"Management of Pregnancy"

- 1 Dr J Robt Buchanan.....Nevada, Mo
"A Plea for Greater Accuracy in our Therapeutics"
- 2 Dr N H Grady.....Monett, Ark
"Pneumonia; its Causation and Treatment"
- 3 Dr W C Bradford.....Shawnee, Okla
"Tuberculosis"
- 4 Dr C S Kenny.....Norcaturn, Kans
"Cholera Infantum"
- 5 Dr Wm Frick.....Kansas City, Mo
"Ringworm"
- 6 Dr F W Shelton.....Independence, Kans
"Medical Treatment in Surgical Diseases"
- 7 Dr A B Leeds.....Chickasha, I T
"Some Observations on the Modern Treatment of Disease"
- 8 Dr J H Moody.....San Antonio, Tex
"Why so many Cases of Drug and Alcohol Addiction Recur After
Treatment"

(General Evening Session)

Dr Wm G Moore,.....St Louis, Mo
Address: "Above all, the Clinician"

SURGICAL SECTION

SECTION OFFICERS.

Chairman, Dr Jabez N Jackson, Kansas City, Mo

Vice Chairman, Dr H L Blesh, Guthrie, Okla

Secretary, Dr B F Fortner, Springfield, Mo

Chairman's Address

Dr Jabez N Jackson, Kansas City, Mo

Dr C R Shinault, Little Rock, Ark

"Drainage in Surgery"

Dr C E Bentley, Little Rock, Ark

(Title to be announced)

Dr Joseph P Runyan, Little Rock, Ark

(Title to be announced)

Dr William E Laws, Hot Springs, Ark

"Diagnosis and Surgical Treatment of some of the Non-tubercular
Diseases of the Knee Joint"

Dr St Cloud Cooper, Ft Smith, Ark

"Intussusception"

Dr J E Gilcreest, Gainesville, Tex

"The Treatment of Wounds"

Dr A C Scott, Temple, Texas

"Abdominal and Pelvic Drainage"

Dr Bacon Saunders, Ft Worth, Texas

"Malignant Diseases of the Mammary Gland, their Diagnosis, Prog-
nosis and Treatment"

Dr G B Foscue, Waco, Texas

(Title to be announced)

Dr Joe Becton, Greenville, Texas

(Title to be announced)

Dr J D Griffith, Kansas City, Mo

"Anatomy of the Lymphatics and Phlegmon of the Abdominal Wall"

Dr. Willard Bartlett, St. Louis, Mo.

"The Value of the Metal Pin for Fractured Long Bones," with a re-
port of nine cases

Dr. Charles H. Wallace, St. Louis, Mo.

(Title to be announced)

Dr Frank J. Lutz, St. Louis, Mo.

"Empyema and its Treatment"

Dr. Walter B Dorsett, St. Louis, Mo.

(Title to be announced)

Dr John Young Brown, St. Louis, Mo.

(Title to be announced)

Dr. Howard Hill, Kansas City, Mo.

"Restoration of the Pelvic Floor"

Dr. Robert McD Schaufler, Kansas City, Mo.

"Lesions of the Sacro-iliac Joint"

Dr. Charles E Bowers, Wichita, Kans.

"Prostatic Hypertrophy in the Aged Male". Abstract Etiology.
Differential Morbid Anatomy. Report of operative cases

Dr. George M. Gray, Kansas City, Kans.

(Title to be announced)

- Dr. F. H. Clark.....El Reno, Okla.
 "Surgical Affections of the Kidneys"
 Dr. A. L. Blesh.....Guthrie, Okla.
 "The Surgical Consideration of Congenital, Oral and Labial Clefts"
 Dr. D. A. Myers.....Lawton, Okla.
 (Title to be announced)
 Dr. Fred S. Clinton.....Tulsa, I. T.
 (Title to be announced)
 Dr. LeRoy Long.....South McAlistier, I. T.
 (Title to be announced)
 Dr. A. E. Hertzler.....Halstead, Kans.
 "Diagnosis and Treatment of Lung Abscess"

SECTION ON EYE, EAR, NOSE AND THROAT

SECTION OFFICERS.

Chairman, E. H. Carey, M.D., Dallas, Texas
 Vice Chairman, H. Moulton, M. D., Ft. Smith, Ark.
 Secretary, J. F. Gsell, M. D., Wichita, Kans

1 Chairman's Address

Dr. Edward H. Carey,.....Dallas, Texas

2 "Operation for Chronic Suppuration of the Frontal Sinus"

Dr. H. Moulton,.....Fort Smith, Ark.

3 "Management of Corneal Injuries"

Dr. R. S. Magee.....Topeka, Kans.

4 "Tonsillectomy and its Necessity"

Dr. Frank Boyd.....Ft. Worth, Texas

5 "The Sumucous Window Resection of the Cartilaginous Septum"

Dr. R. H. T. Mann.....Texarkoma, Ark.-Texas

6 Optic Atrophy (1) Etiology (2) Pathology (3) Differential Diagnosis and Treatment

Dr. L. Haynes Buxton.....Oklahoma City, Okla.

Election of Officers

7 "Glaucoma"

Dr. J. G. Dorsey,.....Wichita, Kans

8 "Ethmoidal Sinus Affections"

Dr. J. E. Sawtell,.....Kansas City, Kans

9 "Trachoma"

Dr. P. P. Fulkerson.....St. Joseph, Mo

10 Paper

Dr. Camp,.....Springfield, Mo

11 Paper

Dr. Zuber N. Short,.....Hot Springs, Ark

12 "The Comparative Value of Chemical and Electrical Cauterization in Hypertropic Conditions of the Nose"

Dr. Turner Robert,.....Paris, Texas

13 "Surgical Treatment of Detached Retina and Report of Several Cases"

Dr. George W. Moser.....Parsons, Kans

BOOKS RECEIVED THIS MONTH FOR REVIEW.

A Treatise on Fractures and Dislocations. By Lewis A. Stimson, B. A. M. D., Professor of surgery in Cornell University Medical College, New York. New (5th) edition, thoroughly revised. Octavo, 847 pages, with 352 engravings and 52 plates. Cloth \$5.00 net; leather \$6.00 net; half morocco \$6.50 net. Lea Brothers & Co., Philadelphia and New York, 1907.

Disease of the Intestines and Peritoneum. By Dr. Herrmann Nothnagel of Vienna. Edited, with additions, by H. D. Rolleston, M.D., F. R. C. P. Physician to St George Hospital, London, England. Second Edition. Octavo of 1509 pages, illustrated. Philadelphia and London; W. B. Saunders Company, 1907. Cloth \$5.00 net; half morocco \$6.00 net.

Surgery: Its Principle and Practice. In five volumes. By 66 eminent surgeons. Edited by W. W. Keen, M. D., L. L. D., Hon F. R. C. S., Eng. and Edin., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Phila. Volume II. Octavo of 920 pages, with 572 text illustrations and 9 colored plates. Philadelphia and London: W. B. Saunders Company, 1907. Per volume: cloth \$70.0 net; half morocco \$8 00 net.

Practical Fever Nursing. By Edward C. Register, M. D., Professor of the Practice of Medicine in the North Carolina Medical College. Octavo volume of 352 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1907. Cloth \$2.50 net.

Gynecology and Abdominal Surgery. In two large octavos. Edited by Howard A. Kelly, M. D., Professor of Gynecologic Surgery at John Hopkins University.; and Charles P. Noble, M. D., Clinical Profesor of Gynecology at the Woman's Medical College, Philadelphia. Large octavo volume fo 851 pages, with 405 original illustrations by Mr. Herman Becker and Mr. Max Brodel. Philadelphia and London: W. B. Saunders Company, 1907. Per volume: cloth \$8.00 net; half morocco \$9.00 net.

Treatment of the Diseases of Children. By Charles Gilmore Kerley, M. D. Professor of Diseases of Children, New York Polyclinic Medical School and Hospital, etc. Octavo volume of 597 pages, illustrate Philadelphia and London: W. B. Saunders Company, 1907. Cloth \$5.00 net; half morocco \$6 50 net.

A Manual of Diseases of the Nose, Throat and Ear. By E. Baldwin Gleason, M. D., Clinical Professor of Otology at the Medico-Chirurgical

College, Philadelphia. 12mo of 556 pages, profusely illustrated. Philadelphia and London: W. B. Saunders Company, 1907. Flexible leather \$2 50 net.

Five Hundred Surgical Suggestions. Practical brevities in surgical diagnosis and treatment. By Walter M. Brickner, B. S., M. D., Chief of Surgical Department, Mount Sinai Hospital Dispensary, New York; Editor-in-Chief, American Journal of Surgery, and Eli Moschcowitz, A. B., M. D., assistant physician, Mount Sinai Hospital Dispensary, New York; Associate Editor, American Journal of Surgery. Second series. Duodecimo; 125 pages. New York: Surgery Publishing Co., 92 William St., 1907. Price \$1.00.

It is not surprising that the first edition of "Surgical Suggestions" was quickly exhausted. The attractive little volume was most favorably received by reviewers, and its contents—the snappy, practical "suggestions"—have been reprinted again and again by medical journals all over the country.

In this second series all the surgical suggestions of the first issue have been incorporated, and as many more, making a total of five hundred terse, useful "therapeutic hints and diagnostic wrinkles." Several new topics have been thus introduced and the old ones much expanded. An index is provided. The paragraphs, as before, have all been suggested by the authors' own observations. Many of them are bits of wisdom that are not to be found in the text-books. We do not believe that even an experienced surgeon will fail to find among these five hundred suggestions some hints that will repay him many fold for the leisure hour spent in reading this small manual. And to those who have not enjoyed many years of active surgical work, five hundred practical, epigrammatic surgical dicta will surely prove immensely helpful. The internist is concerned in the diagnosis of surgical and borderline affections, and to him, also, we commend the many diagnostic hints between the covers of this little book.

As before, the publication has been prepared in a manner worthy of its unique contents. It is a pocket manual de luxe!—printed in attractive Cheltenham type, on antique India tint paper, with marginal headings and subheads in contrasting ink, and with an artistic binding of heavy cloth, gold-lettered.

We warmly commend this book. Those wearied by searching for information through ponderous text-books and lengthy articles will find actual refreshment in Surgical Suggestions, everyone of the 500 paragraphs of which is a separate and useful bit of practical knowledge.

List of Members in Good Standing in the Kansas Medical Society**ALLEN COUNTY.**

W. R. Heylman Iola, Kan.
 H. A. Brown Iola, Kan.
 G. W. Moore Gas, Kan.
 P. S. Mitchell Iola, Kan.
 C. W. Rennick Gas, Kan.
 G. W. Longenecker Elsmore, Kan.
 W. H. McDowell Iola, Kan.
 J. E. Jewell Moran, Kan.
 F. H. Martin Iola, Kan.
 J. S. Bass Iola, Kan.
 S. A. Coffman Iola, Kan.
 L. Tozer Iola, Kan.
 O. L. Garlinghouse Iola, Kan.
 J. H. Hindman Humboldt, Kan.
 J. W. Bolton Iola, Kan.
 O. C. Payne Humboldt, Kan.
 C. J. Halm LaHarpe, Kan.
 H. L. Hendricks Iola, Kan.
 G. E. Lambeth Moran, Kan.

ANDERSON COUNTY.

J. E. Milligan Garnett, Kan.
 J. B. Jones Garnett, Kan.
 Martha E. Cunningham, Garnett, Kan.
 C. L. Simmons Westphalia, Kan.
 A. H. Skillman Mont Ida, Kan.
 E. T. Metcalf Colony, Kan.
 T. A. Hood Garnett, Kan.
 D. O. Taylor Greeley, Kan.
 Thos. Kirkpatrick Garnett, Kan.
 G. A. Blasdel Garnett, Kan.
 W. M. Caton Colony, Kan.
 J. C. Smith Greeley, Kan.
 E. L. Heidrick Welda, Kan.
 R. W. Hull Kincaid, Kan.
 C. F. Milligan Garnett, Kan.
 F. A. Settle Harris, Kan.
 R. C. Splawn Kincaid, Kan.
 Chas. E. Longacre .. Westphalia, Kan.

ATCHISON COUNTY.

C. H. Linley Atchison, Kan.
 A. B. Chase Atchison, Kan.
 W. T. Dingess Atchison, Kan.
 E. P. Pitts Atchison, Kan.
 E. T. Shelly Atchison, Kan.
 C. A. Lilly Atchison, Kan.
 P. S. Moore Effingham, Kan.
 C. J. Cale Huron, Kan.
 A. L. Charles Lancaster, Kan.
 H. Linley Atchison, Kan.
 D. W. Campbell Atchison, Kan.
 C. S. Ferguson Atchison, Kan.
 Lydia Stockwell Atchison, Kan.
 J. P. Blunk Atchison, Kan.
 J. T. Preston Effingham, Kan.
 G. W. Allaman Atchison, Kan.

BROWN COUNTY.

J. J. Comer Willis, Kan.

F. Dunlap Horton, Kan.
 J. M. Eisenbise Fairview, Kan.
 R. L. Funk Powhattan, Kan.
 S. T. Gillespie Reserve, Kan.
 S. J. Herrick Everett, Kan.
 J. D. Horn Horton, Kan.
 G. C. McKnight Hiawatha, Kan.
 A. McGauley Robinson, Kan.
 W. B. McKinstrey Hamlin, Kan.
 E. J. Leigh Hiawatha, Kan.
 L. Reynolds Horton, Kan.
 C. C. Stivers, Jr. Horton, Kan.
 C. C. Stivers, Sr. Horton, Kan.
 R. Steward Powhattan, Kan.
 L. W. Shannon Hiawatha, Kan.
 V. C. VanVoorhis Robinson, Kan.
 J. O. Ward Horton, Kan.
 H. J. Deaver Fairview, Kan.
 F. H. Erwin Merrill, Kan.
 G. S. Graham Fairview, Kan.
 A. C. Davis Hamlin, Kan.
 W. W. Nye Hiawatha, Kan.
 W. G. Atwood Fairview, Kan.

BUTLER COUNTY.

J. R. McCluggage Douglas, Kan.
 D. C. Stahlman Potwin, Kan.
 F. E. Dillenbeck Eldorado, Kan.
 P. B. Smith Augusta, Kan.
 J. S. Klire Eldorado, Kan.
 C. H. McMillin Leon, Kan.
 W. O. Bennett Eldorado, Kan.
 Anna Perkins Eldorado, Kan.
 C. E. Hunt Eldorado, Kan.
 J. B. Carlile Leon, Kan.
 J. D. Hamilton Douglas, Kan.

BARTON COUNTY.

S. S. Meyer Hoisington, Kan.
 Ed Atkins Olmitz, Kan.
 O. P. McPherson Gt. Bend, Kan.
 H. W. Jury Claflin, Kan.
 E. E. Morrison Gt. Bend, Kan.
 G. O. Speirs Ellinwood, Kan.
 A. H. Connett Gt. Bend, Kan.
 R. H. Meade Gt. Bend, Kan.
 F. L. Howe Olmitz, Kan.
 J. H. Morgan Dighton, Kan.
 A. R. Haas Ellinwood, Kan.
 M. L. Daniels Pawnee Rock, Kan.
 A. R. Lash Ellinwood, Kan.
 C. C. Koons Larned, Kan.
 E. C. Button Gt. Bend, Kan.

BOURBON COUNTY.

R. Aikman Ft. Scott, Kan.
 J. B. Carver Ft. Scott, Kan.
 W. L. Griffin Ft. Scott, Kan.
 W. H. Hayes Ft. Scott, Kan.
 M. F. Jarrett Ft. Scott, Kan.
 B. A. McLemore Ft. Scott, Kan.

E. B. Payne Ft. Scott, Kan.
 J. S. Cummings Bronson, Kan.
 J. W. Sheeler Devon, Kan.
 J. L. Daugherty Hiattville, Kan.
 E. E. Anderson Garland, Kan.
 J. T. Holeman Garland, Kan.
 A. J. Wood Fulton, Kan.
 R. R. Hunter Fulton, Kan.
 J. R. Nusman Ft. Scott, Kan.
 W. L. Hopper Ft. Scott, Kan.
 S. C. Hall Ft. Scott, Kan.
 C. A. Van Velzer Ft. Scott, Kan.
 W. S. McDonald Ft. Scott, Kan.
 A. L. Harrar Ft. Scott, Kan.
 W. S. Gooch Mapleton, Kan.
 W. S. Miller Uniontown, Kan.
 A. J. Roberts Ft. Scott, Kan.

CHEROKEE COUNTY.

C. S. Huffman Columbus, Kan.
 J. P. Scoles Galena, Kan.
 H. B. Savage Galena, Kan.
 F. D. Northup Galena, Kan.
 R. M. Markham Scammon, Kan.
 J. H. Boss Weir, Kan.
 H. H. Brookhart Scammon, Kan.
 A. T. Revell Scammon, Kan.
 G. B. McClellan Weir, Kan.
 W. N. Johnson Columbus, Kan.
 J. D. Graham Artesia, N. M.
 J. H. Greene Galena, Kan.
 A. A. Shelly Galena, Kan.
 H. A. Brown Galena, Kan.
 R. S. Mahan East Mineral, Kan.
 A. R. Holmes ———
 R. C. Wear Baxter Springs, Kan.
 R. C. Lowdermilk Galena, Kan.
 F. L. Ball Hallowell, Kan.
 W. R. Scott Columbus, Kan.
 J. H. Boswell Baxter Springs, Kan.
 G. W. Walker Chetopa, Kan.
 C. H. Jores Galena, Kan.
 J. H. Buckles Mineral, Kan.
 P. J. Hendricksen Columbus, Kan.
 H. P. Mahan Parsons, Kan.
 G. P. Bell Mineral, Kan.
 L. W. Baxter Columbus, Kan.
 H. A. Leaming Crestline, Kan.
 Chas. T. Reid Carona, Kan.
 O. L. Young Sherwin, Kan.

CLOUD COUNTY.

A. G. Sexton Clyde, Kan.
 C. F. Leslie Clyde, Kan.
 W. B. Newton Glasco, Kan.
 J. H. Brierly Glasco, Kan.
 G. N. Hartwell Jamestown, Kan.
 F. A. McDonald Aurora, Kan.
 R. J. McLaughlin Hollis, Kan.
 W. R. Priest Concordia, Kan.
 S. C. Pigman Concordia, Kan.
 W. F. Sawhill Concordia, Kan.
 A. J. Weaver Concordia, Kan.

G. W. Coffey Concordia, Kan.
 A. R. Marcotte Concordia, Kan.
 Chas. Caton Concordia, Kan.
 E. Tourigny Aurora, Kan.
 F. E. Way Concordia, Kan.

CLAY COUNTY.

M. W. Harner Clay Center, Kan.
 R. C. Harner Green, Kan.
 B. F. Morgan Clay Center, Kan.
 R. J. Morton Green, Kan.
 D. J. Moore Idana, Kan.
 X. Olsen Clay Center, Kan.
 M. C. Porter Clay Center, Kan.
 S. E. Reynolds Clay Center, Kan.
 J. P. Stewart Clay Center, Kan.
 C. C. Stillman Morganville, Kan.
 R. A. Stewart Russell, Kan.
 T. E. Schwarz Clay Center, Kan.
 G. A. Tull Clay Center, Kan.
 D. P. Cook Clay Center, Kan.
 J. A. Phillipsen Clifton, Kan.
 S. M. Edgerton Leonardville, Kan.
 S. W. Schenberger Industry, Kan.
 C. I. Welsh Clifton, Kan.
 J. E. Hewett Wakefield, Kan.
 W. M. Droll Leonardville, Kan.

CRAWFORD COUNTY.

H. M. Bacon Nelscn, Kan.
 H. H. Bogle Pittsburg, Kan.
 H. B. Caffey Pittsburg, Kan.
 G. E. Cole Girard, Kan.
 H. K. Cowan Midway, Kan.
 D. A. Iliff Cherokee, Kan.
 M. K. Scott Frontenac, Kan.
 J. G. Sandidge Mulberry, Kan.
 A. C. Graves Pittsburg, Kan.
 C. Passuedetti Pittsburg, Kan.
 Wm. Williams Pittsburg, Kan.
 G. W. Williams Pittsburg, Kan.
 J. J. Cavanaugh Walnut, Kan.
 C. R. Tinder Englevale, Kan.
 C. M. Bertholf Cherokee, Kan.
 A. A. Dickinson Pittsburg, Kan.
 L. P. Adamson Girard, Kan.
 F. L. Keeler Farlington, Kan.
 Frances A. Harper Pittsburg, Kan.
 A. O. Blair Pittsburg, Kan.
 Arthur Mcberg Pittsburg, Kan.
 R. B. Gibb Pittsburg, Kan.
 A. M. Smith Cherokee, Kan.
 L. A. Newton Chicopee, Kan.
 Chas. Chapin Frontenac, Kan.
 E. L. Steele Pittsburg, Kan.
 J. F. McNaught Girard, Kan.
 C. A. Dudley Pittsburg, Kan.

COWLEY COUNTY.

C. M. Holcomb Winfield, Kan.
 L. A. Jacobus Winfield, Kan.
 F. B. Emory Winfield, Kan.

T. E. Hinshaw Winfield, Kan.
 W. T. McKay .. Arkansas City, Kan.
 Geo. S. Morris, Arkansas City, Kan.
 G. P. Wagoner Dexter, Kan.
 S. J. Guy Winfield, Kan.
 C. E. Pugh Winfield, Kan.
 H. L. Snyder Winfield, Kan.
 E. F. Day Arkansas City, Kan.
 B. C. Geeslin .. Arkansas City, Kan.
 A. W. Dortch .. Arkansas City, Kan.
 W. H. Monser Burden, Kan.
 C. T. Ralls Winfield, Kan.
 H. C. Burson Maple City, Kan.
 Chas. Dunning .. Arkansas City, Kan.
 J. H. Gwinn .. Arkansas City, Kan.
 G. W. Hawkins Dexter, Kan.
 R. R. Teller Arkansas City, Kan.
 B. F. Hawk Arkansas City, Kan.
 W. H. Carter Atlanta, Kan.
 I. W. Clark Winfield, Kan.
 W. J. Hall Winfield, Kan.
 Ida C. Hall Winfield, Kan.
 C. B. Wyant Winfield, Kan.
 H. C. Binson Maple City, Kan.
 Lloyd Clary Winfield, Kan.
 F. M. Wilmer Winfield, Kan.

DICKINSON COUNTY.

E. E. Hazlett Abilene, Kan.
 J. N. Dieter Abilene, Kan.
 Simeon Steelsmith Abilene, Kan.
 P. B. Witmer Abilene, Kan.
 C. B. Buck Abilene, Kan.
 J. R. Conklin Abilene, Kan.
 Royal McShea Abilene, Kan.
 J. J. O'Brien Chapman, Kan.
 J. D. Riddell Enterprise, Kan.
 Leslie Leverick Solomon, Kan.
 F. M. Gaines Solomon, Kan.
 J. C. Klepinger Herrington, Kan.
 J. N. Ketchersid Hope, Kan.
 S. W. Schenberger Industry, Kan.
 Geo. E. White Holland, Kan.
 W. A. Klingburg Elmo, Kan.
 S. N. Chaffee Talmage, Kan.
 F. W. Montgomery .. Navarre, Kan.
 A. S. Gish Abilene, Kan.
 Schuyler Nichols .. Herrington, Kan.
 W. M. Van Scoyoc, Manchester, Kan.
 G. Greenlee Solomon, Kan.
 E. F. Hoover Enterprise, Kan.
 A. R. Marcotte Enterprise, Kan.
 C. H. Maust Denegal, Kan.

DONIPHAN COUNTY.

A. Herring Highland, Kan.
 J. H. McGahey .. White Cloud, Kan.
 W. M. Boone Highland, Kan.
 Herbert H. Smith .. Highland, Kan.
 J. W. Hebsen White Cloud, Kan.
 R. R. Clutz Bendena, Kan.
 F. E. Horner Severance, Kan.
 S. H. Blakely Severance, Kan.

H. G. Herring Highland, Kan.
 A. E. Cardonier Troy, Kan.

DOUGLAS COUNTY.

E. J. Blair Lawrence, Kan.
 H. L. Charles Leecompton, Kan.
 J. P. Gergen Big Springs, Kan.
 H. T. Jones Lawrence, Kan.
 G. W. Jones Lawrence, Kan.
 G. A. Hammon Lawrence, Kan.
 F. D. Morse Lawrence, Kan.
 E. R. Keith Lawrence, Kan.
 E. Smith Lawrence, Kan.
 F. D. G. Harvey Lawrence, Kan.
 James Naismith Lawrence, Kan.
 E. D. F. Phillips .. Lawrence, Kan.
 B. H. Leslie Lawrence, Kan.
 C. J. Simmons Lawrence, Kan.
 A. W. Clark Lawrence, Kan.
 S. C. Emley Lawrence, Kan.
 Carl Phillips Lawrence, Kan.
 A. J. Anderson Lawrence, Kan.
 A. Gifford Lawrence, Kan.
 M. T. Sudler Lawrence, Kan.
 G. M. Liston Baldwin, Kan.

ELK COUNTY.

W. H. Smithers Moline, Kan.
 W. C. Trowbridge Howard, Kan.
 J. L. Hays Howard, Kan.
 J. F. Costello Howard, Kan.
 C. W. Maddox Longston, Kan.
 B. R. O'Connor Grenola, Kan.
 M. G. Fox Elk Falls, Kan.
 G. H. Grimmell Howard, Kan.
 F. L. Depew Howard, Kan.

GEARY COUNTY.

C. E. Steadman .. Junction City, Kan.
 P. J. Moyer Junction City, Kan.
 F. W. O'Donnell .. Junction City, Kan.
 L. R. King Junction City, Kan.
 W. S. Yates Junction City, Kan.
 T. E. McCord Milford, Kan.
 L. S. Steadman .. Junction City, Kan.

GREENWOOD COUNTY.

L. S. Trusler Fall River, Kan.
 J. Dillon Eureka, Kan.
 N. S. McDonald Severy, Kan.
 S. F. McDonald Severy, Kan.
 D. F. Butcher Severy, Kan.
 B. L. Hale Neal, Kan.
 W. T. Grove Eureka, Kan.
 H. W. Manning Eureka, Kan.
 E. J. Norman Eureka, Kan.
 W. S. Moonlight Eureka, Kan.
 James M. Moore Madison, Kan.
 S. L. Axford Virgil, Kan.
 J. S. Black Madison, Kan.
 J. R. Pusey Quincy, Kan.
 W. H. Yandell Piedmont, Kan.
 A. B. Lewis Hamilton, Kan.

J. M. Winegar Hamilton, Kan.
 C. L. Katz Madison, Kan.
 T. H. Hale Fall River, Kan.
 D. R. Campbell Severy, Kan.
 W. F. Hoover Climax, Kan.

HARVEY COUNTY.

J. T. Axtell Newton, Kan.
 Max Miller Newton, Kan.
 G. D. Bennett Newton, Kan.
 A. E. Smolt Newton, Kan.
 I. L. Abbey Newton, Kan.
 O. W. Roff Newton, Kan.
 J. W. Graybill Newton, Kan.
 R. C. McClymonds Walton, Kan.
 I. T. Smith Newton, Kan.
 S. S. Haury Newton, Kan.
 H. L. Wood Whitewater, Kan.
 A. E. Hertzler Halstead, Kan.
 J. L. Grove Newton, Kan.
 R. S. Haury Halstead, Kan.
 E. E. Watke Halstead, Kan.

HARPER COUNTY.

J. C. A. Bowles Bluff City, Kan.
 B. F. Hawk Bluff City, Kan.
 C. W. Windbigler Harper, Kan.
 G. M. Wooden Anthony, Kan.
 A. D. Updegraff Anthony, Kan.
 A. E. Walker Anthony, Kan.
 B. H. Jordan Waldron, Kan.
 J. A. Hazel Freeport, Kan.
 A. J. McAdams Harper, Kan.

JEWELL COUNTY.

A. B. Peters Mankato, Kan.
 Dorothy D. Allen Mankato, Kan.
 L. A. Carter Randall, Kan.
 O. W. Hughes Jewell, Kan.
 H. M. Hitner Esbon, Kan.
 C. R. Spain Jewell, Kan.
 J. E. Blades Randall, Kan.
 J. W. Johnson Formosa, Kan.
 J. E. Hawley Burr Oak, Kan.
 Chas. Hershner, North Branch, Kan.
 M. B. Sherrard Mankato, Kan.

JACKSON COUNTY.

V. V. Adamson Holton, Kan.
 W. P. Brackett Mayetta, Kan.
 H. F. Carver Circleville, Kan.
 C. W. Culp Hoyt, Kan.
 F. T. Myers Netawaka, Kan.
 Geo. E. Lock Holton, Kan.
 J. W. Pettijohn Hoyt, Kan.
 E. W. Reed Holton, Kan.
 Chas. W. Reynolds Holton, Kan.
 J. E. Love Whiting, Kan.
 J. W. Murray Hoyt, Kan.
 R. Robson Mayetta, Kan.
 J. W. Darlington Denison, Kan.
 J. R. Mainz Whiting, Kan.
 F. W. Noble Circleville, Kan.

J. C. Shaw Holton, Kan.

JEFFERSON COUNTY.

W. A. Aitkins Valley Falls, Kan.
 J. B. Armstead Winchester, Kan.
 L. Atwood Meriden, Kan.
 W. L. Barst McLouth, Kan.
 G. W. England Valley Falls, Kan.
 S. Johnson Oskaloosa, Kan.
 A. D. Lowry Ozawkie, Kan.
 A. G. Smith Oskaloosa, Kan.
 S. E. Smith Grantville, Kan.
 D. D. Wilson Nortonville, Kan.
 J. T. Fulton Donovan, Kan.
 A. C. Zimmermann Perry, Kan.
 Chas. F. Martin Winchester, Kan.
 E. C. Rankin McLouth, Kan.
 W. D. Groff Nortonville, Kan.
 P. Burns Perry, Kan.
 J. L. Work Meriden, Kan.
 Ira Puderbaugh Ozawkie, Kan.
 M. S. McCreight Oskaloosa, Kan.
 W. S. Hunter Valley Falls, Kan.
 C. C. Kerr Perry, Kan.
 L. V. Sams Rock Creek, Kan.

JOHNSON COUNTY.

C. R. Fear Gardner, Kan.
 T. S. Greer Edgerton, Kan.
 F. F. Green Olathe, Kan.
 W. C. Harkey Gardner, Kan.
 H. E. Hastings Olathe, Kan.
 Thos. Hamel Olathe, Kan.
 George Jewett Edgerton, Kan.
 Robert M. Moore Olathe, Kan.
 F. B. Stout Olathe, Kan.
 Jessie Thomas Olathe, Kan.
 H. E. Williamson Olathe, Kan.
 Carl Thomas Spring Hill, Kan.
 C. Warner Jones Lenexa, Kan.
 J. R. Sloan Stanley, Kan.
 Jessie T. Orr Olathe, Kan.
 O. C. Thomas Spring Hill, Kan.

KINGMAN COUNTY.

E. W. Hinton Kingman, Kan.
 H. L. Mills Pensaloosa, Kan.
 J. W. Cheney Kingman, Kan.
 A. C. Johnson New Murdock, Kan.
 Ira D. Nelson Spivey, Kan.
 H. E. Haskins Kingman, Kan.
 M. H. Haskins Kingman, Kan.
 S. W. Nossman Cunningham, Kan.
 J. S. Caldwell Kingman, Kan.
 C. W. Longenecker Kingman, Kan.
 O. A. Duncan Norwich, Kan.
 Chas. E. Phillips Zenda, Kan.
 Eugene Wallace Belmont, Kan.

LYON COUNTY.

G. A. Biddle Emporia, Kan.
 T. C. Biddle Topeka, Kan.
 J. C. Brickell Americus, Kan.

M. D. Brown Lebo, Kan.
 T. G. Burris Allen, Kan.
 L. B. Bushong Admire, Kan.
 C. J. Corbett Emporia, Kan.
 H. E. Davis Emporia, Kan.
 F. A. Eckdall Emporia, Kan.
 F. A. Foucannon Emporia, Kan.
 C. D. Hatcher Admire, Kan.
 Jacob Hindon Strong City, Kan.
 D. F. Longenecker Emporia, Kan.
 J. H. Page Emporia, Kan.
 J. M. Parrington Emporia, Kan.
 S. P. Reeser Hartford, Kan.
 T. E. Welsh Emporia, Kan.
 D. L. Morgan Emporia, Kan.
 C. C. Hughes Hartford, Kan.
 J. F. Hughes Hartford, Kan.
 C. F. Lusk Lebo, Kan.
 H. W. Edgerton Americus, Kan.
 G. M. Gafford Emporia, Kan.
 D. M. Gafford Emporia, Kan.
 J. H. Jaquith Council Grove, Kan.
 C. L. Stocks Bushong, Kan.
 T. O. Brown Reading, Kan.
 L. S. Harvey Dunlap, Kan.
 J. L. Roberts Dunlap, Kan.
 C. A. Neighbors Emporia, Kan.
 C. F. Hoover Saffordsville, Kan.
 C. W. Lawrence Emporia, Kan.

LINN COUNTY.

L. R. Ashley Pleasanton, Kan.
 S. H. Brooks Mound City, Kan.
 H. L. Clark LaCygne, Kan.
 D. E. Green Pleasanton, Kan.
 Geo. W. Vail Parker, Kan.
 T. W. Warner Parker, Kan.
 C. P. Lee Pleasanton, Kan.
 J. G. Wortman Mound City, Kan.
 F. E. Casburn LaCygne, Kan.

LEAVENWORTH COUNTY.

M. L. Crozier Lansing, Kan.
 C. C. Goddard Leavenworth, Kan.
 S. McKee Leavenworth, Kan.
 R. L. Boling Leavenworth, Kan.
 H. J. Stacy Leavenworth, Kan.
 J. S. Wever Leavenworth, Kan.
 E. S. Wood Jarbalo, Kan.
 C. E. Brown Leavenworth, Kan.
 C. K. Vaughn Leavenworth, Kan.
 E. L. Igel Leavenworth, Kan.
 J. W. Risdon Leavenworth, Kan.
 C. M. Moates .. Leavenworth, Kan.
 A. J. Smith Leavenworth, Kan.
 J. D. Miller Leavenworth, Kan.
 S. B. Langworthy, Leavenworth, Kan.
 C. J. McGee Leavenworth, Kan.
 J. L. Everhardy .. Leavenworth, Kan.
 J. N. Phillips Boulder, Col.
 W. B. Coe Tonganoxie, Kan.
 J. L. Pryer Leavenworth, Kan.
 C. Lloyd Leavenworth, Kan.

J. G. Jones Tonganoxie, Kan.

MITCHELL COUNTY.

F. M. Daily Beloit, Kan.
 F. B. Home Beloit, Kan.
 E. N. Daniels Beloit, Kan.
 D. S. O'Brien Beloit, Kan.
 E. E. Brewer Beloit, Kan.
 M. J. Lobdell Beloit, Kan.
 A. J. Seager Beloit, Kan.
 M. R. Spessard Glen Elder, Kan.
 M. R. Barst Beloit, Kan.
 N. J. Saunders Cawker City, Kan.
 E. G. Mason Cawker City, Kan.
 H. L. Ratcliff .. Cawker City, Kan.
 S. T. Bldis Scottville, Kan.
 J. F. Ullman Simpson, Kan.
 J. E. Graff Scottville, Kan.
 W. B. Cook Beloit, Kan.

MARION COUNTY.

L. A. Buck Peabody, Kan.
 O. J. Furst Peabody, Kan.
 L. T. Morrell Peabody, Kan.
 James Welsh Tampa, Kan.
 S. M. Palmer Florence, Kan.
 L. S. Wager Florence, Kan.
 R. C. Smith Marion, Kan.
 J. Werthner Lincolnville, Kan.
 G. P. Marner Lincolnville, Kan.
 Grant Myers Lincolnville, Kan.
 S. E. McIntosh Burns, Kan.
 J. H. Seylor Ramona, Kan.
 H. M. Mayer Peabody, Kan.
 E. H. Johnson Peabody, Kan.
 W. W. Johnson Elbing, Kan.

MONTGOMERY COUNTY.

P. H. Dalby Havana, Kan.
 H. M. Casebeer .. Independence, Kan.
 W. E. Youngs Cherryvale, Kan.
 J. A. Pinkston .. Independence, Kan.
 B. F. Masterman, Independence, Kan.
 Ira B. Chadwick Tyro, Kan.
 D. W. Howell Havana, Kan.
 M. A. Finley Cherryvale, Kan.
 O. W. Demott Independence, Kan.
 E. C. Wickersham, Independence, Kan.
 W. C. Chaney Independence, Kan.
 J. H. Johnson Coffeyville, Kan.
 C. C. Surber Independence, Kan.
 W. C. Hall Coffeyville, Kan.
 Mamie J. Tanquary, Independence, Kan.
 E. D. Tanquary Coffeyville, Kan.
 Mary L. Martin .. Coffeyville, Kan.
 J. R. Scott Independence, Kan.
 F. E. Shelton Independence, Kan.
 T. A. Stevens Caney, Kan.
 G. W. Seacat Cherryvale, Kan.
 J. F. Gard Cherryvale, Kan.
 A. A. Krugg Coffeyville, Kan.
 C. H. Fortner Coffeyville, Kan.
 G. J. Biglow Caney, Kan.
 J. A. Rader Caney, Kan.

J. L. Barker Jefferson, Kan.
 W. F. Blewett Caney, Kan.
 Ida M. Scott Independence, Kan.
 C. I. Caldwell Caney, Kan.
 W. E. Curd Copen, I. T.
 W. P. Booker Caney, Kan.
 J. S. Scott Independence, Kan.

MARSHALL COUNTY.

M. A. Brawley Frankfort, Kan.
 W. E. Ham Beattie, Kan.
 M. S. Thacher Blue Rapids, Kan.
 J. L. Hausman Marysville, Kan.
 W. R. Breeding Marysville, Kan.
 R. S. Fillmore Blue Rapids, Kan.
 D. W. Humfreville Waterville, Kan.
 H. Humfreville Waterville, Kan.
 G. S. Thacher Waterville, Kan.
 J. W. Chambers Waterville, Kan.
 B. P. Hatch Beattie, Kan.
 J. L. Eddington Marysville, Kan.
 E. L. Wilson Sr. Marysville, Kan.
 E. L. Wilson Jr. Marysville, Kan.

MIAMI COUNTY.

J. D. Van Nuys Osawatomie, Kan.
 S. L. Brooking Paola, Kan.
 W. E. Craig Osawatomie, Kan.
 N. C. Spurs Osawatomie, Kan.
 L. L. Uhls Osawatomie, Kan.
 J. H. Haldeman Paola, Kan.
 D. H. Johnson Paola, Kan.
 J. D. Walthall Paola, Kan.
 J. W. Kelly Louisburg, Kan.
 F. H. Redmond Osawatomie, Kan.
 L. R. Sellers Osawatomie, Kan.
 NORTON & DECATUR COUNTIES.
 H. O. Hardesty Jennings, Kan.
 Chas. W. Cole Norton, Kan.
 J. J. Dallal Norcatur, Kan.
 C. C. Funk Jennings, Kan.
 C. S. Kenney Norcatur, Kan.
 W. Munroe Jones Norcatur, Kan.
 Robert H. Smith Oberlin, Kan.
 J. E. Hodgman Long Island, Kan.
 C. G. Brethouwer Norton, Kan.
 W. C. Lathrop Norton, Kan.
 E. L. Davis Dresden, Kan.
 J. M. Gaume Jennings, Kan.
 S. C. Standard Clayton, Kan.

NEMAHA COUNTY.

J. H. Brown Centralia, Kan.
 D. H. Fitzgerald Kelly, Kan.
 J. W. Graham Wetmore, Kan.
 N. Hayes Seneca, Kan.
 U. G. Iles Seneca, Kan.
 Joseph Haig Wetmore, Kan.
 J. C. Mason Goff, Kan.
 G. W. Shelton Oneida, Kan.
 H. G. Snyder Seneca, Kan.
 Benj. Skinner Wetmore, Kan.
 Preston Thompson Corning, Kan.

C. R. Townsend Centralia, Kan.
 A. J. Best Centralia, Kan.
 W. L. Carlyle Sabetha, Kan.
 C. M. Fisher Sabetha, Kan.
 W. A. Haynes Sabetha, Kan.
 I. H. Magill Corning, Kan.
 S. Murdock Sabetha, Kan.
 Harry Reading Sabetha, Kan.
 Geo. Hall Baileyville, Kan.
 R. E. Wright Bern, Kan.
 W. L. Shelton Woodlawn, Kan.
 C. S. Graham Wetmore, Kan.
 S. Murdock Sr. Sabetha, Kan.

OSBORNE COUNTY.

J. B. Armstrong Portis, Kan.
 T. B. Felix Osborne, Kan.
 E. O. Henshall Osborne, Kan.
 H. R. St. John Osborne, Kan.
 T. O. Felix Downs, Kan.
 B. F. Chillcott Osborne, Kan.
 A. C. Dillon Osborne, Kan.
 E. E. Isenberg Natoma, Kan.
 A. A. Thompson Osborne, Kan.
 C. L. Elbnother Downs, Kan.
 G. W. Franklin Downs, Kan.
 R. B. Mays Covert, Kan.
 S. J. Schoop Osborne, Kan.

OTTOWA COUNTY.

C. B. Alpin Delphos, Kan.
 J. F. Brewer Minneapolis, Kan.
 A. L. Cludas Minneapolis, Kan.
 Geo. E. Eye Delphos, Kan.
 Wm. H. Lee Ada, Kan.
 Jno. Miller Minneapolis, Kan.
 C. D. Vermillion Tescott, Kan.
 J. W. Simmons Culver, Kan.
 F. E. Roberts Bennington, Kan.
 Fred Harvey Minneapolis, Kan.

OSAGE COUNTY.

J. M. Heller Osage City, Kan.
 Jas. Ball Melvern, Kan.
 C. C. Seabrook Burlingame, Kan.
 C. F. Marcotte Osage City, Kan.
 W. Main Overbrook, Kan.
 F. E. Schenck Burlingame, Kan.
 D. B. Moore Osage City, Kan.
 A. F. Harrison Scranton, Kan.
 E. F. Milligan Burlingame, Kan.
 S. J. Hampshire Overbrook, Kan.
 Dr. McNally Michigan Valley, Kan.
 J. N. Beesley Topeka, Kan.
 D. W. Melton Burlingame, Kan.

PRATT COUNTY.

C. F. Bucklin Sawyer, Kan.
 M. M. Lottridge Pratt, Kan.
 J. A. H. Webb Preston, Kan.
 Frank Peak Pratt, Kan.
 E. A. Gaston Pratt, Kan.
 Athol Cochran Iuka, Kan.

J. J. Douthart Pratt, Kan.
 C. D. R. Rogers Coats, Kan.
 H. M. Walker Pratt, Kan.
 L. R. Bobzin Cullison, Kan.
 P. K. Gustin Pratt, Kan.

PHILLIPS COUNTY.

R. M. Tinney Kirwin, Kan.
 D. D. Haggard Phillipsburg, Kan.
 E. A. Nelson Phillipsburg, Kan.
 C. E. Nelson Phillipsburg, Kan.
 G. A. Van Diest .. Prairie View, Kan.
 W. G. LeRew Marvin, Kan.

POTTAWATOMIE COUNTY.

W. M. Reitzel Wamego, Kan.
 C. W. Rairdon Lewis, Kan.
 E. L. Simonton Wamego, Kan.
 Benj. Brunner .. Westmoreland, Kan.
 W. P. Wilson .. Westmoreland, Kan.
 R. F. Richardson Onaga, Kan.
 J. W. Wilhoit St. George, Kan.
 A. Cutright Louisville, Kan.
 P. T. Conlan St. Marys, Kan.
 L. A. Summers Wheaton, Kan.
 J. W. Luch Olsburg, Kan.
 C. H. Kcentz Onaga, Kan.
 S. R. Toothaker Wheaton, Kan.
 J. E. McManus Havensville, Kan.
 O. R. Searl Belvue, Kan.
 B. K. Kilborne Emmett, Kan.
 W. F. McDougall Wamego, Kan.
 J. M. Jennings Wamego, Kan.

ROOKS COUNTY.

James Parker Woodson, Kan.
 E. E. Colby Woodson, Kan.
 N. L. Book Stockton, Kan.
 W. B. Callender Stockton, Kan.
 D. L. Sackrider Webster, Kan.
 D. F. Stoigh Stockton, Kan.
 Chas. E. Barber Palco, Kan.
 F. K. Meade Plainville, Kan.
 G. R. Rice Plainville, Kan.
 Harry C. Brown Webster, Kan.
 P. W. Beckman Plainville, Kan.

RENO COUNTY.

R. A. Stewart Hutchinson, Kan.
 J. E. Stewart Hutchinson, Kan.
 D. B. Southard Haven, Kan.
 S. M. Callady Hutchinson, Kan.
 H. J. Duvall Hutchinson, Kan.
 J. E. Feltz Hutchinson, Kan.
 G. R. Gage Hutchinson, Kan.
 W. H. Bauer Sylvia, Kan.
 W. F. Schoor Hutchinson, Kan.
 C. Klipple Hutchinson, Kan.
 S. H. Sidlinger Hutchinson, Kan.
 H. S. Justice Hutchinson, Kan.
 Virgil Beavers Hutchinson, Kan.
 J. W. Maguire Hutchinson, Kan.
 C. A. Mann Hutchinson, Kan.
 E. V. Adams Plevna, Kan.

C. S. Evans Partridge, Kan.
 T. O. Blair Turon, Kan.
 H. H. Heylman .. Hutchinson, Kan.
 E. H. Kasey Hutchinson, Kan.
 G. E. Webb Hutchinson, Kan.
 M. C. Roberts Hutchinson, Kan.

RILEY COUNTY.

C. F. Little Manhattan, Kan.
 J. D. Colt Manhattan, Kan.
 L. J. Lyman Manhattan, Kan.
 E. J. Moffitt Manhattan, Kan.
 W. D. Silkman Manhattan, Kan.
 T. R. Cave Manhattan, Kan.
 C. A. Roberts Randolph, Kan.
 G. H. Litsinger Riley, Kan.
 A. G. Henderson .. Leonardville, Kan.
 J. C. Montgomery .. Manhattan, Kan.
 W. H. Clarkson Manhattan, Kan.
 F. L. Murdock Manhattan, Kan.

RICE COUNTY.

P. P. Trueheart Sterling, Kan.
 H. R. Ross Sterling, Kan.
 W. E. Currie Sterling, Kan.
 C. E. Fisher Lyons, Kan.
 L. E. Vermillion Lyons, Kan.
 J. S. McBride Lyons, Kan.
 E. C. Fisher Lyons, Kan.
 F. R. Smith Little River, Kan.
 J. H. Powers Little River, Kan.
 F. W. Koons Chase, Kan.
 F. E. Wallace Frederick, Kan.
 Marion Trueheart Sterling, Kan.
 C. I. Forney Lyons, Kan.
 L. O. Forney Saxman, Kan.
 G. E. Bush Geneseo, Kan.
 A. H. Bressler Raymond, Kan.
 H. T. McLaughlin Sterling, Kan.
 Dr. Arderson Saxman, Kan.
 D. J. Muir Alden, Kan.
 RAWLINS & CHEYENNE COUNTIES.
 J. N. Melugin Atwood, Kan.
 L. G. Graves Atwood, Kan.

REPUBLIC COUNTY.

C. M. Arbutnot Belleville, Kan.
 J. S. Billingsly Belleville, Kan.
 J. C. Decker Belleville, Kan.
 J. W. Eckblad Scandia, Kan.
 D. E. Foristall Republic, Kan.
 T. C. Long Munden, Kan.
 W. G. Hanning Belleville, Kan.
 C. V. Haggman Scandia, Kan.
 J. H. Houk Argenda, Kan.
 J. D. Johnson Republic, Kan.
 Wm. Kamp Belleville, Kan.
 W. I. McFarland Belleville, Kan.
 J. C. Sharrard Norway, Kan.
 F. J. Petr Cuba, Kan.
 J. B. Henry Scandia, Kan.
 S. J. Snider Courtland, Kan.
 Jcs. A. Kahout Cuba, Kan.

SEDGWICK COUNTY.

C. E. McAdams Wichita, Kan.
 J. M. Latta Wichita, Kan.
 J. C. Brown Wichita, Kan.
 D. W. Basham Wichita, Kan.
 D. I. Maggard Wichita, Kan.
 G. C. Purdue Wichita, Kan.
 F. J. Walker Wichita, Kan.
 E. M. Palmer Wichita, Kan.
 J. F. Gsell Wichita, Kan.
 J. G. Dorsey Wichita, Kan.
 E. E. Hamilton Wichita, Kan.
 J. W. Cave Wichita, Kan.
 H. S. Hickok Wichita, Kan.
 J. W. Kirkwood Wichita, Kan.
 C. E. Bowers Wichita, Kan.
 I. B. Lyons Wichita, Kan.
 C. E. Seott Wichita, Kan.
 G. K. Purvis Wichita, Kan.
 C. E. Caldwell Wichita, Kan.
 J. D. Clark Wichita, Kan.
 A. H. Fabrique Wichita, Kan.
 J. E. Oldham Wichita, Kan.
 W. T. Logsdon Wichita, Kan.
 Martin Hagan Wichita, Kan.
 Jacob Z. Hoffman Wichita, Kan.
 E. S. Hymer Wichita, Kan.
 H. L. Scoles Mt. Hope, Kan.
 Wm. Sterrett Mt. Hope, Kan.
 S. M. Anderscn Mt. Hope, Kan.
 D. G. Euley Valley Center, Kan.
 W. P. Greening Valley Center, Kan.
 L. P. Warren Clear Water, Kan.
 H. H. Miner Cheney, Kan.
 C. M. Fullenwider Wichita, Kan.
 Robert Baker Mt. Hope, Kan.
 S. A. Bass Wichita, Kan.
 F. S. Williams Wichita, Kan.
 E. H. Taggart Wichita, Kan.
 R. B. Blue Wichita, Kan.
 P. Newman Wichita, Kan.
 F. E. Braucht Wichita, Kan.
 J. D. Barrett Wichita, Kan.
 J. L. Evans Wichita, Kan.
 C. D. Furey Wichita, Kan.
 O. G. Hutchinson Wichita, Kan.
 A. D. Jones Wichita, Kan.
 H. Michener Wichita, Kan.
 K. B. Ford Wichita, Kan.
 F. A. Kelly Wichita, Kan.
 W. A. Phares Wichita, Kan.
 J. A. Connor Viola, Kan.

SALINE COUNTY.

N. D. Toby Salina, Kan.
 W. H. Winterbotham Salina, Kan.
 W. S. Harvey Salina, Kan.
 W. B. Dewees Salina, Kan.
 J. R. Crawford Salina, Kan.
 J. W. Neptune Salina, Kan.
 H. N. Moses Salina, Kan.
 J. H. Winterbotham Salina, Kan.
 A. G. Anderson Salina, Kan.

O. R. Brittain Salina, Kan.
 E. R. Tuttle Salina, Kan.
 L. O. Nordstrom Assaria, Kan.
 A. J. May New Cambria, Kan.
 E. R. Cheney Gypsum, Kan.
 E. W. Hawthorn Gypsum, Kan.
 C. D. Armstrong Salina, Kan.
 M. J. Brown Salina, Kan.
 W. E. Fowler Brookville, Kan.
 E. J. Lutz Salina, Kan.
 J. E. Metcalf Salina, Kan.
 O. D. Walker Salina, Kan.
 J. W. Simmons Lindsborg, Kan.

SOUTHWEST JOINT.

T. L. McCarty Dodge City, Kan.
 C. B. Leslie Meade, Kan.
 C. E. McCarty Dodge City, Kan.
 G. F. Johnson Lakin, Kan.
 K. T. Nichols Liberal, Kan.
 A. B. Scott Jetmore, Kan.
 J. C. Bredhoft Ford, Kan.
 Wm. Lee Meade, Kan.
 O. L. Helwig Garden City, Kan.
 W. H. Graves Dodge City, Kan.
 H. Whitworth Dodge City, Kan.
 Hubert Farnen Dodge City, Kan.
 D. W. Thompson Dodge City, Kan.
 T. S. Higginbotham Liberal, Kan.
 C. S. Smith Liberal, Kan.
 G. B. Ingles Jetmore, Kan.

SUMNER COUNTY.

S. T. Shelly Mulvane, Kan.
 H. A. Vincent Perth, Kan.
 Eugene Pile Portland, Kan.
 Melvin Collins Oxford, Kan.
 R. A. McElhenny, Conway Springs, Kan.
 F. M. Owens Argonia, Kan.
 T. J. Hollingsworth, South Haven, Kan.
 J. J. Sippey Belle Plains, Kan.
 W. E. Bartlett Belle Plains, Kan.
 H. B. Morton Mayfield, Kan.
 F. G. Emerson Wellington, Kan.
 S. W. Spitler Wellington, Kan.
 J. L. Halliday Wellington, Kan.
 J. A. Rice Wellington, Kan.
 H. L. Ccbean Wellington, Kan.
 L. F. Harmen Wellington, Kan.
 T. H. Jamison Wellington, Kan.
 W. M. Martin Wellington, Kan.
 J. M. Hunt Wellington, Kan.
 G. R. Waite Milan, Kan.
 I. T. Sabhart Caldwell, Kan.
 D. E. Kisicker Caldwell, Kan.
 F. B. May Hunnewell, Kan.
 H. E. Hoke South Haven, Kan.
 W. H. Neel, Jr., Anson, Kan.
 W. H. Neel, Sr., Mayfield, Kan.
 E. N. Williams South Haven, Kan.
 J. F. Robertson Caldwell, Kan.
 E. G. Ferris Conway Springs, Kan.

E. A. Evans .. Conway Springs, Kan.
 J. A. Robb Ashton, Kan.
 R. H. Shippey Peck, Kan.
 W. H. Rea Wellington, Kan.
 L. S. Coplan Wellington, Kan.
 L. G. Millington .. Wellington, Kan.
 R. H. Downing Corbin, Kan.

SMITH COUNTY.

B. W. Slagle Smith Center, Kan.
 D. W. Relihan .. Smith Center, Kan.
 J. A. McCammon .. Reamsville, Kan.
 L. A. Golden Kensington, Kan.
 J. B. Dykes Lebanon, Kan.
 H. A. Dykes Lebanon, Kan.
 S. B. Dykes Esbon, Kan.
 W. C. Bower Lebanon, Kan.
 F. M. Bilby Kensington, Kan.
 W. H. Bostwick Cedarville, Kan.
 H. O. Hardesty Reamsville, Kan.
 E. W. Tallman Gaylord, Kan.

STAFFORD COUNTY.

J. N. Rcse Stafford, Kan.
 J. P. H. Dykes Stafford, Kan.
 G. W. Sectt Stafford, Kan.
 Cyrus Wesley Stafford, Kan.
 John McDonald St. John, Kan.
 M. M. Hart Macksville, Kan.
 C. S. Adams St. John, Kan.
 F. S. O'Flyng Seward, Kan.
 F. W. Trethbar Hudson, Kan.
 W. S. Crouch Stafford, Kan.
 T. W. Sectt Stafford, Kan.

SHAWNEE COUNTY.

H. L. Alkire Topeka, Kan.
 Harriet E. Adams Topeka, Kan.
 A. S. Andrews Topeka, Kan.
 J. A. Berry Topeka, Kan.
 E. M. Brackett Topeka, Kan.
 Ida C. Barnes Topeka, Kan.
 A. W. Carson Richland, Kan.
 O. P. Davis Topeka, Kan.
 D. E. Esterly Topeka, Kan.
 B. D. Eastman Topeka, Kan.
 F. J. Ernest Topeka, Kan.
 J. D. Freeman Topeka, Kan.
 W. R. Frisbey Topeka, Kan.
 L. Y. Grubbs Topeka, Kan.
 Sara Greenfield Topeka, Kan.
 T. B. Hegeboom Topeka, Kan.
 G. W. Hegeboom Topeka, Kan.
 H. H. Hazlett Topeka, Kan.
 S. A. Johnson Topeka, Kan.
 C. E. Judd Topeka, Kan.
 J. M. Jamison Topeka, Kan.
 J. P. Kaster Topeka, Kan.
 J. P. Lewis Topeka, Kan.
 W. S. Lindsay Topeka, Kan.
 L. H. Munn Topeka, Kan.
 J. C. McClintock Topeka, Kan.
 W. E. McVey Topeka, Kan.

R. E. McVey Topeka, Kan.
 C. A. McGuire Topeka, Kan.
 R. S. Magee Topeka, Kan.
 J. E. Minney Topeka, Kan.
 G. J. Mulvane Topeka, Kan.
 H. C. Miner Topeka, Kan.
 M. R. Mitchell Topeka, Kan.
 W. C. McDonough Topeka, Kan.
 T. W. Peers Topeka, Kan.
 L. M. Powell Topeka, Kan.
 R. S. Plummer Topeka, Kan.
 F. H. Schalle Topeka, Kan.
 S. G. Stewart Topeka, Kan.
 W. D. Steers Topeka, Kan.
 O. A. Taylor Topeka, Kan.
 N. J. Taylor Berryton, Kan.
 W. A. Wehe Topeka, Kan.
 W. L. Warriner Topeka, Kan.
 H. A. Warner Topeka, Kan.
 C. B. Van Horn Topeka, Kan.
 Geo. M. Minney Topeka, Kan.
 Thos. R. Hyatt Topeka, Kan.
 W. W. Yates Topeka, Kan.
 Robert Stewart Topeka, Kan.
 C. W. Schwartz Topeka, Kan.
 J. R. Fay Topeka, Kan.
 C. W. Stahl Auburn, Kan.
 S. A. Hammel Topeka, Kan.
 J. H. Outland Topeka, Kan.
 J. B. Tower Topeka, Kan.
 Josephine Eskom Topeka, Kan.
 W. F. Bowen Topeka, Kan.
 W. L. Schenck Topeka, Kan.
 W. H. Righter Topeka, Kan.
 J. C. Bennett Topeka, Kan.
 E. V. Coldren Topeka, Kan.
 S. F. Millard Topeka, Kan.
 W. C. Van Camp Topeka, Kan.
 S. J. Crumbine Topeka, Kan.
 T. C. Biddle Topeka, Kan.
 C. F. Menninger Topeka, Kan.
 Otto Kline Topeka, Kan.

NO COUNTY ORGANIZATION.

J. A. Fuller Lane, Kan.
 W. S. Grisell Ransom, Kan.
 H. Z. Hissem Ellsworth, Kan.
 Geo. Nicholson Plains, Kan.
 M. S. Reynolds .. Yates Center, Kan.
 O. E. Smith Leoti, Kan.
 W. T. Fletnitz Dorrance, Kan.
 C. W. Rairden Lewis, Kan.

WASHINGTON COUNTY.

E. Armstrong Greenleaf, Kan.
 R. Algie Linn, Kan.
 J. H. Hcover Haddam, Kan.
 H. D. Smith Washington, Kan.
 M. H. Horn Morrowville, Kan.
 Wm. Jacobs Washington, Kan.
 J. O. Chambers Hanover, Kan.
 W. M. Earnest Washington, Kan.
 Z. H. Snyder Palmer, Kan.

M. N. Gardner	Greenleaf, Kan.	John Troutman	Kansas City, Kan.
R. A. Williams	Washington, Kan.	A. J. Lind	Kansas City, Kan.
W. S. Runkle	Washington, Kan.	O. M. Longenecker	Kansas City, Kan.
J. R. Matthews	Hollenberg, Kan.	C. A. Foulks	Kansas City, Kan.
G. E. Tooley	Washington, Kan.	Jas. W. May	Kansas City, Kan.
R. W. Maintz	Linn, Kan.	C. J. Lidikay	Kansas City, Kan.
H. M. Ochiltree	Haddam, Kan.	F. J. Lutz	Kansas City, Kan.
E. W. Shearburn	Haddam, Kan.	S. H. Thompson	Kansas City, Kan.
C. R. Nelson	Washington, Kan.	Hugh Wilkinsn	Kansas City, Kan.
D. C. Tyler	Clifton, Kan.	Preston Sterritt	Kansas City, Kan.
G. W. Duvall	Hollenburg, Kan.	J. H. McGregor	Kansas City, Kan.
		Thos. Richmond	Kansas City, Kan.
		W. D. Fairbank	Kansas City, Kan.

WILSON COUNTY.

B. R. Riley	Coyville, Kan.	J. O. Milner	Kansas City, Kan.
E. N. Martin	Eenedict, Kan.	J. A. Fulton	Kansas City, Kan.
C. E. Duncan	Fredonia, Kan.	J. A. Davis	Kansas City, Kan.
F. M. Wiley	Fredonia, Kan.	L. F. Barney	Kansas City, Kan.
A. C. Plack	Fredonia, Kan.	Jessie Newkirk ..	Kansas City, Kan.
A. P. Williams	Neodesha, Kan.	F. P. Clark	Kansas City, Kan.
C. L. Williams	Neodesha, Kan.	F. Campbell	Kansas City, Kan.
O. D. Sharp	Neodesha, Kan.	G. W. Richards	Kansas City, Kan.
L. L. Jones	Altocna, Kan.	J. W. Faust	Kansas City, Kan.
J. C. Preston	Buffalo, Kan.	Z. Nascn	Kansas City, Kan.
F. K. Day	Neodesha, Kan.	J. J. McCalman	Piper, Kan.
T. Blakeslee	Neodesha, Kan.	Ottaker Hoffman	Argentine, Kan.
J. F. Jones	Neodesha, Kan.	G. H. Hoxie	Rosedale, Kan.
J. W. McGuire	Neodesha, Kan.	C. L. Zugg	Argentine, Kan.
F. T. Allen	Neodesha, Kan.	L. D. Mabie	Kansas City, Kan.
J. Morehead	Neodesha, Kan.	A. T. Swan	Kansas City, Kan.
J. H. Allen	Neodesha, Kan.	E. R. Tenney	Kansas City, Kan.
W. H. Addington	Altocna, Kan.	J. L. B. Eager	Kansas City, Kan.
A. H. Rogers	Altocna, Kan.	D. M. Smith	Argentine, Kan.
W. H. McConnell	LaFontain, Kan.	D. E. Clopper	Argentine, Kan.
F. H. Rhoades	New Albany, Kan.	R. C. McClure	Argentine, Kan.
		J. G. Sheldon	Rosedale, Kan.
		G. L. A. Hamilton	Kansas City, Kan.
		D. W. Thompson ..	Kansas City, Kan.
		C. B. Stemen	Kansas City, Kan.
		J. T. Kecgler	Kansas City, Kan.
		M. B. Roberts	Kansas City, Kan.

WABAUNSEE COUNTY.

C. R. Silverthorn	McFarland, Kan.
Geo. M. Jeffers	Esbridge, Kan.
Chas. H. Milke	Alma, Kan.
C. E. Smith	Alma, Kan.
C. E. Menard	Maple Hill, Kan.
G. W. B. Beverly	Alma, Kan.
A. A. Myer	Alma, Kan.
Geo. A. King	Paxico, Kan.
W. H. H. Smith	Altavista, Kan.

WYANDOTTE COUNTY.

G. M. Gray	Kansas City, Kan.
R. A. Roberts	Kansas City, Kan.
P. D. Hughes	Kansas City, Kan.
C. M. Stemen	Kansas City, Kan.
R. C. Lawman	Kansas City, Kan.
S. S. Glascecek	Kansas City, Kan.
F. M. Tracy	Kansas City, Kan.
A. S. Paversh	Kansas City, Kan.
Martta M. Bacon	Kansas City, Kan.
W. F. Waite	Kansas City, Kan.
J. G. Poble	Kansas City, Kan.
B. F. Sharp	Kansas City, Kan.
J. F. Hassig	Kansas City, Kan.
J. E. Sawtell	Kansas City, Kan.
Anna K. Masterson	Kansas City, Kan.
P. M. Barnett	Kansas City, Kan.

WESTERN KANSAS.

V. C. Eddy	Celby, Kan.
F. A. Carmichael	Goodlard, Kan.
C. M. Miller	Oakley, Kan.
C. S. Marsh	Menlo, Kan.
A. C. Gulick	Goodland, Kan.
F. H. Smith	Goodland, Kan.
W. J. Lewis	Gem, Kan.
D. R. Storer	Quinter, Kan.
H. A. Straup	Winona, Kan.
W. M. Beaver	Celby, Kan.
D. M. Fchrer	Seldcn, Kan.
E. J. Beckrer	Seldcn, Kan.
C. D. Blake	Ellis, Kan.
C. H. Gillman	Oakley, Kan.
T. H. Howell	Ellis, Kan.
J. H. McNaughton	Cove, Kan.
E. D. Eeckner	Hoxie, Kan.
C. W. Winslow	Oakley, Kan.

McPHERSON COUNTY.

Geo. R. Dean	McPherson, Kan.
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J. C. Hall McPherson, Kan.
 A. Engberg McPherson, Kan.
 J. B. Alexander .. McPherson, Kan.
 C. D. Weaver Galva, Kan.
 E. O. Smith Marquette, Kan.
 V. I. Vestling Marquette, Kan.
 J. C. Ulery Windom, Kan.

NEOSHO COUNTY.

W. K. Mathis Chanute, Kan.
 Geo. H. Brown Chanute, Kan.
 L. D. Johnson Chanute, Kan.
 J. B. Edwards Chanute, Kan.
 M. A. Duncan Chanute, Kan.
 R. A. Light Chanute, Kan.
 U. G. Hoshaw Chanute, Kan.
 F. R. Hickey Chanute, Kan.
 O. M. Edwards Chanute, Kan.
 J. C. Lardner Chanute, Kan.
 P. F. Wellman Chanute, Kan.
 J. W. Barker Chanute, Kan.
 W. E. Barker Chanute, Kan.
 A. M. Davis Chanute, Kan.
 H. E. Rakestraw Chanute, Kan.
 E. A. Davis Chanute, Kan.
 J. Allen Palmer Erie, Kan.
 J. J. McNamara St. Paul, Kan.
 M. E. Lake Erie, Kan.
 G. W. Morgan Kimball, Kan.
 C. L. Randall Morehead, Kan.
 W. C. McConnell .. Morehead, Kan.
 R. C. Henderson Chanute, Kan.
 J. H. Light Chanute, Kan.
 G. C. Thompson Galesburg, Kan.
 T. R. Edwards Chanute, Kan.

LABETTE COUNTY.

J. M. Kleiser Parsons, Kan.
 T. B. Allison Parsons, Kan.
 G. S. Liggett Oswego, Kan.
 E. E. Liggett Oswego, Kan.
 I. B. Kackley Parsons, Kan.
 R. M. Bennett .. Mound Valley, Kan.
 H. L. Markham Parsons, Kan.
 C. F. Brady Parsons, Kan.
 M. L. Perry Parsons, Kan.
 O. S. Hubbard Parsons, Kan.
 A. L. Skoog Parsons, Kan.
 J. B. Anderson Chetopa, Kan.
 R. L. VonTrebra Chetopa, Kan.
 E. W. Boardman Parsons, Kan.
 G. W. Maser Parsons, Kan.
 J. C. Creel Parsons, Kan.
 Albert Smith Parsons, Kan.
 G. W. Gabriel Parsons, Kan.
 J. W. Henderson Labette, Kan.
 James Heacock Parsons, Kan.
 P. W. Barbe Oswego, Kan.

J. T. Tinder Parsons, Kan.
 C. N. Petty Altamont, Kan.
 A. D. Smith Parsons, Kan.
 A. M. Painter Parsons, Kan.
 G. H. Wellbrook Parsons, Kan.
 M. F. Crawford Parsons, Kan.

COFFEY COUNTY.

J. C. Fear Waverly, Kan.
 C. L. Davidson Waverly, Kan.
 A. K. Berry Burlington, Kan.
 B. F. Egan Waverly, Kan.
 W. H. Mathis Waverly, Kan.
 V. McMullin Burlington, Kan.
 D. B. Rowe LeRoy, Kan.
 H. T. Salisbury Burlington, Kan.
 G. R. Noris Burlington, Kan.
 M. L. Stockton Gridly, Kan.

LINCOLN COUNTY.

O. W. Shalksohm, Sylvan Grove, Kan.
 Otto F. Dierker .. Sylvan Grove, Kan.
 James Loughridge .. Lincoln, Kan.
 H. L. Hinkle Barnard, Kan.
 G. W. Anderson Beverly, Kan.
 H. M. Butler Orgallah, Kan.
 A. W. Townsend Barnard, Kan.
 W. A. Hulen Lincoln, Kan.
 A. Hultner Lincoln, Kan.
 H. M. Hall Lincoln, Kan.

WOODSON COUNTY.

D. W. Maxson Toronto, Kan.
 H. W. West Yates Center, Kan.
 E. K. Kellenberger, Yates Center, Kan.
 G. W. Lee Toronto, Kan.
 M. D. Elder Pequa, Kan.
 B. F. Browning ... Yates Center, Kan.
 S. J. Bacon Yates Center, Kan.
 A. J. Lieurance .. Neosho Falls, Kan.

CHAUTAUQUA COUNTY.

G. W. Goss Sedan, Kan.
 P. E. Garrison Sedan, Kan.
 W. T. Courtwright Sedan, Kan.
 Milton T. Evans Sedan, Kan.
 P. N. Whitney Cedarvale, Kan.
 B. F. Finn Cedarvale, Kan.
 W. L. Jack Chautauqua, Kan.
 Fred Calhoun Peru, Kan.
 W. L. McNaughton Elgin, Kan.
 R. S. Lynn Chautauqua, Kan.
 H. S. Lamden Peru, Kan.
 Wm. Floyd Peru, Kan.
 J. D. Stevens Peru, Kan.
 J. M. Ennis Cedarvale, Kan.
 L. D. Lout Cedarvale, Kan.
 D. G. Hahn Wauneta, Kan.

THE JOURNAL OF THE
OBITUARY.

William Marvyn Brownlee Boon, M. D., was born in Chetopa, May 7, 1873, and died July 24, 1907, aged thirty-four years, two months and seventeen days. Dr. Boon's early schooling was received in the Chetopa public school. At the age of eighteen he entered Monmouth College, where he attended a course of lectures for one year, after which he commenced the study of medicine, taking the first three years course at Rush Medical College at Chicago, completing his course and receiving his diploma from Jefferson Medical College, Philadelphia.—Chetopa Clipper, July 31.

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THE USE OF ADRENALIN DURING ETHER ANESTHESIA.

By CHARLES S. VENABLE, M. D., Charlottesville, Va.

From The Virginia Medical Semi-Monthly, Feb. 22, 1907.

Recognizing that my experience in the use of Adrenalin during ether anesthesia is but very limited, covering a course of only eighteen cases, and knowing the many fallacies attendant upon too early conclusions, I feel great hesitancy in making this report. However, owing to the uniform result that has attended its use, I am prompted to do so now.

I found that 25 per cent. aqueous solution of the standard 1 in 1000 gave the best results, and that by first pouring ether in the towel cone and spraying the Adrenalin solution on it, depending on the ether to vaporize it sufficiently for inhalation, was the best mode of administration. Three to six minute intervals are sufficient for its use and a total of from one-half to one ounce of this solution is enough for an operation lasting from thirty minutes to an hour. The effects are a more uniform etherization, the pulse becomes steadier, slower and of better character more rapidly than under ether alone; respirations are quiet and regular, the bronchial secretions are practically checked, and the progress of the operation is not interrupted.

These cases were not selected, and among them were old alco-

holics; two women over sixty, one of them nearly eighty years of age. Three of them were very long, tedious operations, lasting over two hours, and in none of the series was any stimulation required during the anesthesia.

Recovery from the anesthetic was uniformly good; there was practically no post-operative shock, and no stimulation was needed in any one of the cases; only two patients vomited at all and very little nausea was complained of.

From the foregoing facts I conclude that, owing to the contraction of the smaller vessels the bronchial glands secrete less mucus, and there is better aeration in the bronchioles and pulmonary vesicles, less ether is required to produce anesthesia and there is less probability of ether pneumonia following. The Adrenalin, acting generally from absorption, is a powerful stimulant; it materially lessens shock, lessens the capillary ooze at the field of operation, and is of great benefit to the much weakened patient.

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Antiphlogistine Versus Opium.

The Medical Era.

Inflamed states of the various organs of the body frequently give rise to pain of such urgent character as to demand active steps looking to its relief. Upon seeing the patient for the first time (he has called his physician because his suffering has become intolerable), the medical attendant is met with a peremptory demand for relief from the suffering.

With a willingness, which frequently overrides their better judgment, some physicians resort to the hypodermic needle indiscriminately, and, in too many cases, a greater evil has followed the lesser one. The free habit of using morphine or some other form of opium is not a judicious practice, and for several reasons. The exact seat of an inflammation, for instance, might become difficult to locate, and thus a clear diagnosis is interfered with. But the greater objection to the use of opium is the possibility of adding a recruit to the ever growing army of habitues.

Every time there occurs to a doctor the apparent need for opium he should deliberate well before resort is had to the needle. If, after careful consideration, his best judgment advises the use of opium, it should be given in some form by mouth. If the needle is used the patient at once knows what he is getting, but he is not so likely to acquire this information if it be given otherwise.

For relieving the pain of the inflammations Antiphlogistine

will easily take the place of opium. The relief following may not be so prompt and so complete, but the edge of the suffering is taken off within a short time, and soon the patient is in a comfortable condition and has escaped the possibility of becoming addicted to a drug. There is not the likelihood that a patient, relieved from pain by it, will begin eating or using Antiphlogistine in any other way—which likelihood is the greatest disadvantage of opium.

In the future let your morphine become stale, and keep your Antiphlogistine fresh—use it in inflammation.

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The Cure of a Case of Osteomalacia.

In an article on the suprarenal glands and osetomalacia, in the Munich Med. Wochenschrift, 1907, P. 278, L. M. Bossi, of Genoa, describes the almost marvelous cure of a serious case of osteomalacia by subcutaneous injections of Adrenalin. The patient was a multipara, 38 years of age, who was enceinte in the eighth month and had a well defined osteomalacis. After seven hypodermic injections of Adrenalin, each of which consisted of one-half cg. of Adrenalin of the 1:1000 solution, the patient fully recovered.

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Nutrients.

Nutrition spelt with a big N should be one of the largest words in the vocabulary of the physician. The weak, the delicate, and those who are below par from over-work or imperfect development should be nourished often times to the point; almost, we were disposed to say, of "stuffing." Of course the proper nourishment of our patient at all stages of disease is important, and in the acute period for a time the proper nutrition really means judicious starvation or the withholding of food until the digestive tract can be plaeced in a condition to do its work. Beef tea, time out of mind, has been one of the chief standbys of the sickroom, but as a matter of fact we know now that which we should have known long ago, that the average beef tea is a fraud, and that it is no more nutritious than a weak toddy would be; that it is practically nothing but water with a few soluble salts of the beef contained therein.

The only way that we can hope to give the elements of nourishment in a concentrated form, represented by beef fibre, is to order a commercial extract of beef, and in doing so we should be sure that the product which we order is made by a skillful pharmacist. The Charles N. Crittenton Company has for years been furnishing to the profession a most efficient product of beef under the name of C Olden's Liquid Beef Tonic, which is most valuable in all forms of

wasting diseases and in cases of convalescence from severe illness. It is indeed a food medicine, which is promptly assimilated and which interrupts and prevents the breaking down of vital tissues; and one great advantage to the patient is that it is agreeable to the taste and acceptable to the most delicate stomach.

Typhoid Fever and Modern Treatment.

Good elimination should be maintained from every gland and emunctory, writes W. T. Marrs, of Peoria Heights, Ill. Every secretion should be aroused and made to do its best. Calomel in small doses is one of our best remedies. Salines are nearly always indicated. Abbott's Saline Laxative is pleasanter and better than crude salts. He has observed that if the bowels act not less than twice daily, the course and severity of the disease is modified. The old idea that in typhoid the bowels should be kept confined for a few days at a time, is now looked upon as having been an untenable theory. The more debris and toxins are eliminated, the less will the disease be compelled to oxidize by the process of fever. The more water the patient drinks, the more are poisons eliminated or diluted, thus lessening their absorption. In case of hyperpyrexia, give a colonic flushing and the high temperature usually comes down a degree or two. The sulphocarbolates (W-A Intestinal Antiseptics) should be given to neutralize remaining foci of infection. Patients treated along this line seldom require the cold bath. Tepid spongings at frequent intervals usually serve a better purpose than the bath of low temperature.—Merck's Archives.

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WHAT IS THE MATTER WITH KANSAS—VITAL STATISTICS?

CRESSY L. WILBUR, M. D., Chief Statistician Department of Commerce and Labor, Bureau of the Census, Washington, D. C.

Mr. President and Members of the Kansas State Medical Society:

In a recent issue of the Century Magazine, under the title: "Sorrows of a Skipper," may be found a poem from which I extract a few touching stanzas:

"I hates to think of dyin'," says the skipper to the mate;
"Starvation, shipwrecks, heart disease I loathe to contemplate.
I hates to think of vanities and all the crimes they lead to—"

Then says the mate
With looks sedate,
"Ye doesn't reely need to."

"The chances is ag'in us," says the skipper in dismay,
"If fate don't kill us out and out, it gits us all some day;
So many perish of old age, the death rate must be fearful—"

"Well," says the mate,
"At any rate
We might as well die cheerful."

"I read in them statistic books," the nervous skipper cries,
"That every minute by the clock some feller up and dies.
I wonder what disease they gits that kills in such a hurry!"

The mate he winks
And says "I thinks
They mostly dies of worry."

The skipper would not have been unduly alarmed at the incidence of mortality if he had confined his reading of "statistic books" to the Kansas mortality reports—and had been sanguine enough to believe what he read, without investigation or question, as some readers of statistics do.

In the last published report, the second biennial, for the years

1903 and 1904, a considerable portion of the volume, beginning on page 139, is occupied with what purports to be the "Vital Statistics for Kansas, comprising the returns of marriages, births, and deaths; also annual reports of county health officers." Looking at these pages Kansas would seem to be unusually fortunate in its registration facilities and to take an unusual interest in vital statistics, because there are TWO separate sets of reports included in the statistical presentation, which duplicate the data, so far as the returns are complete, for the entire state. We find (1) returns of births, marriages and deaths from assessors for the years ending March 1, 1903, and March 1, 1904, from which a table of causes of deaths by counties has been compiled; and also (2) returns from county health officers for the calendar years giving the total number of deaths and deaths from communicable diseases. Surely in the duplication of this work a fair degree of completeness should be arrived at, but a cursory comparison of the "statistics" shows that both sets of returns are utterly worthless for all the important practical purposes that the registration of vital statistics should subserve.

Following is a comparative table showing the total number of deaths, with "death rates" based upon the annual census enumerations of population for the state, for the years, included in the biennial report:

KANSAS HAS TWO SYSTEMS OF COLLECTING MORTALITY STATISTICS, EACH GIVING WORTHLESS RESULTS.

Returns from	Year ending	Counties not Reporting	Total deaths returned	Population	"Rates" per 1,000
Assessors	Mar. 1, 1903	8	7,222	(1) 1,452,217	5.0
Assessors	Mar. 1, 1904	8	7,470	(2) 1,469,969	5.1
Health officers	Dec. 31, 1903	22	8,908		6.1
Health officers	Dec. 31, 1904	17	10,707	(3) 1,534,471	7.0

(1) State Census 1902; (2) State Census 1903; (3) State Census 1904

It should be noted with respect to the total number of deaths shown in the above table that many counties fail to make any reports whatever both in the assessors' and health officers' returns. The so-called "death rates" given above are not the ratios of re-

ported deaths to reporting population, but are merely the ratios of the total number of deaths reported to the aggregate population that ought to be represented in the returns. They are, of course, ridiculously low and have no scientific value whatever, except to indicate how grossly imperfect the systems of registration now in force in Kansas must be to yield such incomplete returns.

Their quality is as bad as their numbers are scanty. The skipper's nerves would be disturbed by many worthless statements of causes of death. It has been known for many years that no satisfactory mortality statistics can be collected by ENUMERATION, such as the assessors are required by law to make each year in this state. Medical terms are sadly mangled when thus obtained, and many indefinite and wholly valueless statements are recorded. For example, there were returned and actually compiled under the heading of "Complications," 28 deaths in the year ending March 1, 1903, and 49 from this cause, which is quite unique in mortality reports—for the year ending March 1, 1904. Undoubtedly from this statement, "Complications," as a cause of death, is rapidly on the increase in Kansas and in time may be expected to become as fatal as "Heart failure," another title which, in mortality statistics, is considered as practically equivalent to no statement at all as to cause of death, but which in Kansas, in the year ending March 1, 1903, caused 196 deaths, and in the following year 269 deaths—that is, according to the assessors.

It is absolute folly to attempt to collect statistics of deaths in any such way. The cause of death should be entered by the physician on a certificate of death, which should be required as a necessary prerequisite before interment. There is no other way, so far as the experience of sixteen registration states as shown, in which a complete record of all deaths that occur can be obtained, and a record that is not complete is simply a nuisance, so far as its statistical and sanitary value is concerned.

It is of very great importance not only to the state, but to the nation, that an effective law for the registration of deaths should be enacted in Kansas. You have undoubtedly seen the reference to the movement in the Bulletin of the Kansas State Board of Health. In the issue for November, 1906, it was stated that "It is a well known fact that accurate and complete vital statistics of Kansas can never be gathered under the present law and system, and as accurate statistics must be the underlying basis for proper interpretation of sanitary conditions in the state, it follows that such interpretation cannot be accurately made, nor the appropriate preventive

measures applied, until such time as exact data can be secured." And in the message of Governor Hoch to the last legislature of Kansas, he says: "Our laws for the collection of accurate and complete statistics of births and deaths in this state are very inadequate, and as these statistics are of vital importance in order to a proper understanding of sanitary conditions, these laws should be strengthened and made more effective."

The importance of this movement to the country at large is expressed by the following joint resolutions passed by congress and approved by the president on February 11, 1903:

RESOLUTIONS BY CONGRESS.

Joint Resolution Requesting State Authorities to Co-operate With Census Office in Securing a Uniform System of Birth and Death Registration.

Whereas, the registration of births and deaths at the time of their occurrence furnishes official record information of much value to individuals; and

Whereas, the registration of deaths, with information upon certain points, is essential to the progress of medical and sanitary science in preventing and restricting disease and in devising and applying remedial agencies; and

Whereas, all of the principal countries of the civilized world recognize the necessity for such registration and enforce the same by general laws; and

Whereas, registration in the United States is now confined to a few states, as a whole, and the larger cities, under local laws and ordinances which differ widely in their requirements; and

Whereas, it is most important that registration should be conducted under laws that will insure a practical uniformity in the character and amount of information available from the records; and

Whereas, the American Public Health Association and the United States Census Office are now co-operating in an effort to extend the benefits of registration and to promote its efficiency by indicating the essential requirements of legislative enactments designed to secure the proper registration of all deaths and births and the collection of accurate vital statistics, to be presented to the attention of the legislative authorities in non-registration states, with the suggestion that such legislation be adopted: Now, therefore,

Resolved, by the Senate and House of Representatives of the United States of America in Congress assembled, That the Senate and House of Representatives of the United States hereby express approval of this movement and requests the favorable consideration and action of the state authorities, to the end that the United States may attain a complete and uniform system of registration.

Approved February 11, 1903.

The special interest of the medical profession in this subject has been recognized since the very beginning of vital statistics in

the United States, and its continuance is shown by the following extract from a resolution passed by the American Medical Association:

Resolved, That the American Medical Association strongly urges on the state medical societies that special committees be appointed to advocate and secure the passage of satisfactory registration laws in states that do not at present possess them; that county societies support and aid in the execution of such laws as far as possible, and that physicians individually, throughout the United States, endeavor to promote the accuracy and value of the mortality statistics by giving clear and definite statements of causes of death on certificates of death.

I believe, therefore, in view of the preceding evidence, that it is proper to ask the State Medical Society of Kansas to take an active interest in the passage of effective legislation for the registration of vital statistics, and believe that a committee of representative members of the society should be appointed for this purpose at the present session. As the legislature does not meet again until 1909, there will be ample time to draft an acceptable bill, have it thoroughly discussed by the profession throughout the state, and present it for approval at the next annual meeting of this society, when the committee should be continued to urge its passage through the legislature. It is only by organized work that results can be obtained.

A bill was introduced at the last session by Senator Ingalls, drafted along the general line of the present registration law of Pennsylvania, which has proved a thorough-going success, and at the official request of the secretary of the State Board of Health of Kansas, and to show the active interest taken by the Federal Government, I went from Washington to Topeka to personally appear before the Joint Committee of the House and Senate in its behalf. I found, however, that the attention of the committee was very much distracted by other pressing matters, and that there was no organized representation of the medical profession in behalf of such legislation. Much interest was expressed by members of the legislature, and I have no doubt whatever but that a movement thus organized will meet with success.

Kansas can well afford to maintain, not wastefully or extravagantly, but also without penuriousness, a thorough system of registration of deaths. The cost is not great and the study of accurate records will enable the State Board of Health and every sanitary official in the state to be thoroughly equipped with the knowledge of where the causes of disease exist, as is very forcibly stated by

Dr. Samuel G. Dixon, State Health Commissioner of Pennsylvania:

If the department of health is to wage a successful warfare against communicable diseases and to be able to save the lives of those who are unnecessarily sacrificed by them, then it must be familiar with the haunts and habits of disease, the age, occupation and sex of those dying, and for these facts it must look to vital statistics.

Nothing has been quite so cheap heretofore in Pennsylvania as human life, if we are to judge of its value by the records maintained by the state.

The alert and vigilant man of business maintains his books of account and enters therein his every transaction. The depletion and replenishment of his resources, the deterioration or increment of his capital—these facts all necessary and essential to a safe conduct of his affairs. How much more necessary is it, therefore, that we record those facts which are necessary for us to maintain the integrity of the individual, the family, the community.

The cost of collecting, registering and tabulating this great mass of statistics has been a trifle less than four cents each, while the cost to the counties has been practically the same as under the old law.

This is not a large amount, and the expense of registration in the counties is but slight. It is not worth while, however, to attempt to put in any "cheap and nasty" system, or to get something for nothing by expecting physicians to make voluntary returns of deaths to county health officers, and the county health officers, who frequently work for nothing or almost nothing, to compile these returns and make gratuitous reports to the state.

The burden of reporting deaths should be placed upon the undertaker or other person who removes the evidence of death. He should file a certificate with the local registrar before interment or removal. The local registrar should have supervision over a well defined district, should receive a reasonable compensation from the county, say twenty-five cents for each death registered, and should make his returns directly to the state registrar. This system is economical and efficient. It has been thoroughly tested in practical use, and will give good results, and as cheaply as can be expected from any system. The money spent for printing blanks, in payment for returns and for compilation of the two sets of statistics now collected in Kansas, is practically wasted, for the results are worthless. There is no reason why an up-to-date, effective system should not be installed as a result of action by the next session of the legislature, and I hope that this society, through its committee, and also through the interest of its individual members, will co-operate with the State Board of Health in helping to pass a satisfactory law. In this purpose the Bureau of the Census will be pleased to co-operate, and will send to any members of the society,

publications* containing information in regard to the progress of this movement.

DISCUSSION.

Dr. Lutz:—No one seems to take any interest in this very vital question. Our legislators are too busy on other pressing matters. Dr. Wilbur came especially to Kansas to present a bill that was prepared by the State Board of Health pertaining to the legislation on births and deaths, but the legislator has not seen fit to care for himself and family: but, he has seen fit to take care of the railroads and other matters that are not nearly so vital to the welfare of the community as this. We have in this city since the first of the year a system of registration as recommended by President Roosevelt and carried out in Pennsylvania and other states. Before this system went into practice we had 15 or 16 births reported where we now have 25. The deaths were reported only partially. If the physician saw fit to report, he did so. If he saw fit to report a death from tuberculosis, he reported it merely as such—never stating whether it was tuberculosis of the larynx, joints, bowels, lungs, or what. When he had a case die from carcinoma, he put carcinoma or cancer, without saying of what organ. If he saw fit to give the age, he did so. A great many times he failed to put in male or female. He sent it in without his name sometimes. Now, it is different. Since we have this new law in the city, it is very much better. It is very essential that we give attention to vital statistics. When a baby is born, it cannot walk to the Board of Health and say "Here I am. Such and such a man is my father and such a woman is my mother." The physician must see to this. We are responsible for these conditions. If we pay attention to them, very soon this matter can be remedied. If this matter be agitated in the different societies, we can bring it to a focus. Pennsylvania is very much pleased. There are twelve other states where this law is followed. We are recognized in this state as a legislation city. We are in touch with the Board of Health. I should like to see this society appoint a committee of three, giving them some money for expense, say \$50 00, to get this matter before the legislature.

Dr. Crumbine:—I regret very much that I just got to the city a few moments ago and did not hear the paper and be able to take part in the discussion; but, if I may be permitted, I should like to say that the errors which occur are not caused by our not having the right kind of blanks. That is a small part of the difficulty that comes before us. We have a cumbersome and worthless system for collecting these statistics. Perhaps

*The following publications of the Bureau of the Census relating to this subject are available for distribution: No. 71, Registration of Deaths, including a paper on the "Essential Requirements of a Law for the Registration of Deaths and the Collection of Mortality Statistics." No. 101, Practical Registration Methods. No. 104, Registration of Births and Deaths—Drafts of Laws and Forms of Certificates. No. 106, Extension of the Registration Area for Births and Deaths—A Practical Example of Co-operative Census Methods as Applied to the State of Pennsylvania. A general account of the movement will also be found in the introduction to the special report on "Mortality Statistics 1900 to 1904."

the law is not entirely at fault in this matter. It is in the main. But, the fact remains that we physicians are very much at fault. I find it so in collecting these statistics all over the state. It happens frequently that perhaps the most prominent physician in the community is the most dilatory.

(Dr. Crumbine was asked to talk more at length along this line, as there was a hiatus in the program and they would all be interested in his remarks).

The first proposition, Mr. President, that appeals to me is that the registration of vital statistics must be the very basis of all sanitary science and legislation. In order to know anything of the laws of disease and to devise or construct remedies for disease, we must know something of these statistics. How can the tax collector collect his taxes if he does not know the address of the man whom he is to tax? How can the police department supervise a district unless it knows something of the haunts and habits of its criminals? Until such time as we have trustworthy data, our efforts will be very much at sea and much of the result be worthless. Now what are vital statistics? Vital statistics consist of a report of the principal events of every human life. What are the principal events? Birth, marriage and death. I believe that every citizen is entitled to that report. The United States has a great position in this world, yet it is the only civilized country that has not a competent system for the collection of vital statistics. It is not due to a lack of intelligence, for our scientific men are many and prominent in the world. It is caused by our method of government. We have an accumulation of states loosely bound together and the parental government has no such say in any of these matters; hence, the states must do these things. We have sixteen states and the District of Columbia, which are now recognized as registration states. Kansas City, Kansas, (due to our friend, Dr Lutz) has this honor as a city. It is necessary for reasons already indicated; because it is the only possible registration: but, it is also necessary from a legal standpoint. What are some of the necessities from a legal standpoint? Here is a matter of the settlement of estates, the collection of life insurance, and births, and marriages, etc., etc., all dependent on these records. We are called upon day after day to give these records and we are absolutely helpless to do anything. Now, I just want to read one or two extracts of some of the thoughts of our best men along these lines, which I think will interest you; Dr. John S. Fulton, secretary of the State Board of Health of Maryland, says:

"Public hygiene is built upon, is controlled and directed by, and is everlastingly in debt to vital statistics. The might and the right to direct the future of preventive medicine, to make and to terminate contracts, to approve and reject risks, to test materials and methods, to invest means and to distribute profits—these things belong inalienably to vital statistics. Every wheel that turns in the service of public health must be belted to this shaft, otherwise preventive medicine must remain invertebrate and unable to realize the profits available from the magnificent offerings of collateral science. If the unborn historian of hygiene in the twentieth century shall find one anomaly more curious than any other it will be that the twentieth century, opening with prodigious resources, immediately available, ran a third or half its course before these resources became so

standardized that each unit of power might be accounted for in a definite scheme of vital statistics."

I certainly can subscribe to what the doctor has said. This Kansas State Medical Society is a powerful body; and, I believe if it will take hold of this matter that the proper laws will be passed in the next two years.

Dr. Johnson:—I do not know how it is in every county, but I know that I have never been able to get a blank to make a report on. I have written again and again, with varying excuses as a result. He has no blanks ready—will send one in a short time, etc. It has been three years and I have no blanks yet. I think there will have to be some other form of looking after the statistics. The physician has not time to do it. Some other method should be instituted by which the statistics can be taken in the local counties.

Dr. Stemen:—I think the profession is ready at all times to do its duty in this matter. But, there are some things that are sometimes required that are unreasonable. We are asked to give the name of the patient. Many babies are not named. People sometimes wait six months before naming them. I have known doctors who have had reports sent back of a still-born babe because they had not given the name! Such things are unreasonable. If the family could be required to send the name to the Board of Health, it would relieve the physician of this clerical work—work that he cannot very well do. I remember one time asking a woman for the name of her child—she said they named their horses and christened their children. There is one of the difficulties in making these reports. I believe the profession is willing to do its part. It is important that we should stand by the Board of Health and get these statistics. In the state where I lived, they passed a law making a commissioner of health of each county. He was paid a salary to give his entire time to that work. You could not get a burial permit without going to his office. If you buried without that permit, the coroner would be charged to remove the body. That expense was charged to the undertaker. Such a man should be a bacteriologist and chemist. We did not need to diagnose a case of diphtheria. It was his business to go there and make a diagnosis. That kind of a law, I think, would be a very good one. It would relieve the physician and stamp out contagious and infectious diseases. The doctors themselves are not careful enough after tending contagious diseases. I knew a man who was out seeing a case of scarletina—he did not think he would carry it. He went home, took his little girl on his lap; she took scarlet fever and died. We know these things can be carried. This quarantine and the study of prevention of diseases are things of vast importance. My experience is that the profession stand ready to do anything that they can do in the prevention of disease.

Dr. Barnett:—There is no question but the old way of gathering vital statistics through the assessors and county board of commissioners who are the Board of Health of the county is a very poor method. To illustrate: In my town we had an assessor at one time who was gathering these vital statistics and in a case of death he returned "Died, for want of breath" This same man was at one time a member of the school board. He was corresponding with a number of teachers. He wrote a letter to a young

lady applicant in which he said: "You will please answer by return mail." That is the kind of people who usually collect these vital statistics. Whether they ever reach the vital point or not, is the question. We have an organized board of health in Rosedale that is as perfect as that of which Dr. Lutz has spoken. When a birth occurs, it is properly reported on blanks furnished by the board of health. When a death occurs, the body can not be taken out of the city without a certificate from the physician (or, the coroner fills it out, if there be no physician.) There is one thing that has not been mentioned that seems to be of some importance; that is, that the report blanks of the city and those of the county do not correspond. These should be uniform.

Dr. Hamilton.—The Board of Health is responsible for certain physicians not reporting their cases; because they require things that are absurd. Dr. Stemen mentioned one point—concerning the name of an infant. We do not get enough remuneration to run around six months to find out the name of the babe. One case I reported; where it said "Give the name of the babe," I put "I don't know." The health officer said: "If you do not know, keep on going until you find out." I am not going around for six months to find out the babe's name. Many children are not named until they are that old. The board of health should do that. Dr. Lutz has said that many times the reports are not made properly, they are not definite. The local point of the disease is not reported. On that point, I have only to say that many times we are called just in time to give them a death certificate. We do not see the patient at all. I know a case where I was called about a month ago, where a child died of tuberculosis. They had not had a physician for six months, perhaps never, and they called me and asked me to make examination. I made such examination as I could and I found that it was tuberculosis; but, the exact focus I could not make out, because it was late. I had not heard of that case for about a week, when an undertaker came and asked me for a death certificate. He said there had been no other physician. I did not know how to report it. I telephoned in and asked Dr. Lutz about it. I put tuberculosis of the lungs; but, that was not a conscientious report, because I knew nothing of it. I think the board of health should have some arrangements whereby they themselves should see to the different reports.

—o—

More \$5 Insurance Companies.—Following the action of the Mutual Life Insurance Company, in restoring the flat \$5 examiner's fee, it is announced that the Equitable, the Union Central and the Fidelity Mutual have decided to adopt the \$5 fee. It is probable that this break in the combine will soon be followed by the other original \$5 companies and some which previously paid but \$3.

THE USE AND ABUSE OF SALINE SOLUTIONS.

By FRANK A. CARMICHAEL, M. D., Goodland, Kan.

To definitely trace the history of the employment of saline solutions in the treatment of hemorrhage and shock I have found a somewhat difficult task. Doubtless the idea of blood substitution originated many generations ago. Transfusion was advocated and practiced as early as 1556 by Cardanus, who states that the belief was prevalent at that time that old age might be made to assume the character of youth by this method.

Christopher Wren in 1656 first conceived the idea of introducing medicine directly into the circulation though to Denis and Emeriez of Paris may be accorded the record of the first successful transfusion.

Kronecker and Landerer (Berliner Med. Wochenschrift 1879 No. 152) succeeded in rescuing dogs after $\frac{3}{4}$ of their estimated blood had been removed by transfusion. Various substances were used with a view to replenishing blood losses. Transfusion of animal blood, defibrinated blood, the fresh milk of goats and cows, etc. until finally the use of neutral or alkaline solutions of sodium-chloride were evolved.

In this country as early as 1887 Lawson Tait advocated and used large quantities of normal salt solution in the peritoneal cavity following intra abdominal operations as a prophylactic against shock and to combat the evil effects of extensive hemorrhage. Hilderbrand of San Francisco presented a paper on the subject which has since become classical.

Perhaps one of the earliest exponents of this measure was Dawbarn who spent the winter of '90 and '91 in an experimental study of the methods of preventing shock and in January, '92 (N. Y. Med. Record) presented his first paper on this subject, and as early as November '92 (N. Y. Med. Record) prophesied the routine employment of this measure in the prevention of shock and the relief of those distressing symptoms consequent on severe hemorrhage.

In the past few years the sphere of usefulness of this valuable agent has broadened and extended until its value as a remedial agent is recognized by all.

From undisputed sources in the treatment of conditions associ-

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ated with extreme diarrhoeal tendencies or by constant and intractable vomiting its value in replenishing depleted tissue fluids has been frequently proven. In condition of gastric, ulcer and carcinoma where sufficient fluids cannot be taken through other channels it has often been the means of prolonging life, relieving suffering and sometimes tiding the patient over a crisis that otherwise would have proven fatal. The efficiency of its administration by slow continuous or intermittent bowel irrigations in cases of diffuse peritonitis and its beneficial effects in assisting in the elimination of septic products is vouched for by such men as Murphy, Blake and many others.

Its intravenous administration combined with blood-letting has met with signal success in the treatment of uraemic convulsions, the so-called process of blood washing, though considering its efficiency in this condition, allowance must be made for the well known favorable influence of bleeding in convulsive conditions in general, doubtless due to lowered arterial tension. Crile has demonstrated that the convulsions incident to lethal doses of strychnine in the dog may be controlled by bleeding the animal until the blood pressure is greatly reduced and per contra that the administration of heroic doses of strychnine when pressure in the arterial system is low, is likely to result in convulsive seizures when the pressure is subsequently raised by the administration of intra venous infusion.

Thus we may readily see that the role played by salines in the treatment of these conditions is plainly a minor one, if indeed it has any effect whatever, the recently advocated theories of chloride retention arguing against its employment, although as the theory of chloride retention in nephritic conditions is still a matter of controversy except in such cases as are characterized by marked oedema and the beneficial results of saline solutions in combating the prostration and weakness following severe blood losses is established beyond question, its administration cannot as yet, be said to be contra indicated.

The almost marvelous results following its administration in cases of impending shock and exsanguination have placed it easily at the head of all single agents in the treatment of these conditions. There are several factors to be considered in connection with its employment that practically govern the results obtained and the statistics bearing on its use.

1. It is usually employed as a last resort and after heroic cardiac stimulation has failed to secure a reaction, and when the case seems almost hopeless.

2. It is frequently employed indiscriminately in the treatment of shock and hemorrhage alike, its employment being more or less empirical, without due reference to the causative factors producing the phenomena or a clear conception of the vascular conditions obtaining.

3. Its administration in out patient practices is in many cases attended by difficulties as to appliance and asepsis, which are more imaginary than real.

4. It is often employed with an absolute disregard for its contra-indications or the dangers underlying its injudicious administration.

Obviously the employment of any therapeutic measure undertaken for the relief of an abnormal condition, presupposes sufficient vital force on the part of the patient to appropriate the remedial agent. Unfortunately in the use of salt solutions this is frequently overlooked. Therefore it is in the consideration of the most important indication for the employment of saline infusions viz: impending shock, that the old adage "An ounce of prevention" must be strictly borne in mind, for a quart of normal salt solution judiciously administered in a case of THREATENED SHOCK is worth a barrel of it when the condition is established and in progress, and the employment of this measure in cases where the patient is in profound shock or is moribund cannot produce results other than detrimental, as the vital forces are at such a low ebb that the solution cannot be taken up by the system if given under the skin, frequently remaining as an unsightly ecchymotic area or an extensive subcutaneous bleb, and if given by vena clysis, the danger of overpowering an already weak and anaemic heart, one stimulated to the point of complete exhaustion cannot but be apparent to all, for it must be remembered that in all cases of pronounced anaemia whether acute or chronic, the tendency is toward a weakened cardiac musculature and dilatation.

As the theory of the production of shock at the present time assumes the condition to be due to a primary over stimulation and consequent exhaustion of the vaso motor centers, the inconsistency of farther cardiac stimulation is apparent to all, and as the capacity of the venous trunks is many times that of the arterial system the fallacy of administering large quantities of salt solution in cases of established shock must be fully recognized.

Therefore, it cannot be too emphatically reiterated that a sharp distinction must be made between the indications for saline administration in cases of hemorrhage and those of pronounced

shock independent of hemorrhage, and that agents most valuable in the treatment of the one are not only valueless but often provocative of disastrous results in combatting the other.

In the treatment of shock in progress, uncomplicated by hemorrhage the employment of salines is ill advised. Here we have to deal with a paresis of the vessel walls, an intra arterial hemorrhage, if you please, primarily induced by overstimulation of the vaso motor centers, resulting in vascular relaxation and the determination of the blood mass to the great splanchnic trunks, the reduced blood pressure being due to lack of muscular tonus in the vessel walls, not to deficiency in the blood volume but to an inhibition of the forces governing arterial pressure.

It is true that in these conditions we have in a way, the same pathological conditions present as in hemorrhage, viz: anaemia but an anaemia of a far more grave and potent character inasmuch as we have as yet such an imperfect armament with which to meet it. It must be apparent that it is just as logical to pump the system full of saline solution in cases of acute cardiac dilatation as in these cases where the vessel walls are incapable of withstanding the pressure of the blood volume already present.

Its administration in hemorrhage accompanied by pronounced fall in blood pressure, fulfills both a physiologic and mechanical indication. The reduced blood pressure due to depletion of the vascular media demands replenishment of the circulating fluid; the depleted blood stream is not sufficient to fill the arterial trunks; the peripheral resistance is decreased, the heart contracts against a lessened resistance in the arterial tree; imperfect oxygenation of its musculature results in disturbed innervation, with rapid and feeble responses, air hunger and usually mental excitement.

In these cases the most happy and uniform results are obtained from saline solutions, the method of administration varying with the urgency of the case and preference of the attendant, its isotonic properties and the rapidity with which it is taken up by the circulation rapidly increasing the pulse tension often virtually snatching victory from defeat.

The method of administration is determined by circumstances and the immediate demands of the patient; thus it may be preferred to give it by way of the sub-cutaneous tissues in those cases where the circulatory condition are such as to justify a reasonable assurance of its appropriation. In others not requiring such rapid absorption, where the condition is unsatisfactory but not alarming, its administration by the bowel frequently meets the requirements

and is quickly and easily accomplished, being divested of the detail of asepsis.

Perhaps in the majority of cases, however, the conditions are so urgent and alarming that the administration via the vein is considered the method of choice, alone or supplemented by adenalin, brandy or both. It is in these cases where the requirements of the case are so urgent and the conditions of the patient so alarming that the observations of recent investigators along this line must be recalled.

Crile (Int. Jour. Surg. Dec. 1906) has demonstrated that venaclysis when too rapidly administered, may result in acute cardiac dilatation, and when administered in excessive quantities, the excess is not retained within the vessel walls but is eliminated at a proportionate ratio to that of administration by way of the alimentary canal, and when amounts exceeding 320 cc per kilo are administered, the death of the patient from respiratory failure, due to interference with the action of the diaphragm and lower ribs may occur.

Nearly all observers agree that the most satisfactory results are obtained from the administration of saline solutions at a temperature somewhat higher than that originally advocated. (110 F).

Making due allowance for the dissipation of heat in transit and considering the stimulative effect of heat when applied directly to the heart muscle, the use of a solution at a temperature of 120 F or even slightly higher, as advocated by recent investigators, may be considered perfectly safe as only slight crenation of the corpuscles is obtained at 130 F and 160 F are required to produce intravascular clotting.

More especially is the administration of hot salines indicated in those cases exhibiting sub-normal temperature the inadequate oxygenation of the blood consequent upon venous dilatation being responsible for the lowered temperature. In these cases the stimulative effect of heat upon the musculature of the vessel walls as well as its effect in raising the body temperature cannot be denied.

In the light of recent investigation the best results are obtained from a nine-tenths per cent. solution administered at a temperature of 120 F, heat being one of the most efficient remedies at our disposal both internally and externally. In all cases where it is deemed probable that their administration will be beneficial they should be given early in order to secure the best results.

It is now generally recognized by operators of wide experience that the employment of salt solutions in the treatment of head injuries, especially in cases of depressed fracture accompanied by

shock or hemorrhage, or both, is not only without value, but is distinctly harmful in its effects.

A brief consideration of the various dangers attendant upon its administration is permissible, though the extreme urgency of the case in most instances justifies a partial disregard for these, some of which are purely hypothetical. In hypodermeclysis the principal dangers are from a lack of asepsis and failure in absorption of the fluid.

The first may result in a spreading infection or localized abscess, while the second is more likely to occur in conditions of profound shock, in which, if uncomplicated by hemorrhage, the measure is not only useless but detrimental, becoming large unsightly areas of oedematous tissue of purplish hue, which appear post mortem as great blebs of blood stained fluid. Those of vena clysis are:

1. Thrombosis or embolism from trauma to the intima of the vessel by canula, ligature or laceration in attempts to reach its lumen: The first is especially favored by the low arterial pressure usually present while the second may occur hours or days later when the normal tension is restored.

2. Air embolism from air that has not been expelled from the tube before the introduction of the canula or from administration through a funnel that has not been kept full.

3. Unfavorable influence of solutions of less than normal alkalinity.

The most recent physiologic researches have shown that the percentage of sodium chloride in the blood is .84 per cent. instead of .6 per cent as formerly held. A .9 per cent sodium chloride solution having the same freezing point and osmotic pressure as blood. The difference between .84 per cent. and .9 per cent representing probably and amount contributed to the osmotic effect by the many other constituents of the plasma. Thayer and McCallum have repeatedly produced mitral and aortic insufficiency in the dog by flooding the arterial system with salt solutions.

Dawbarn has pointed out the intensely haemolytic action of solutions containing an insufficiency of sodium chloride, citing an experiment on a dog where his assistant had forgotten to add the salt to the solution, the dog dying almost as rapidly as from prussic acid poisoning.

In summarizing therefore we may say that in the experience of those who have employed the method most extensively, the following facts are established:

1. We have no other single remedy that has proven so efficient when its administration has been timely.

2. In order to be efficient in the treatment of shock, it should be administered when the condition is THREATENED, at which time its value is beyond dispute, but when shock is in progress and is profound in character its administration is ill advised unless it be desired to use it as a medium for conveying other remedies as adrenalin.

3. Its injudicious administration is not devoid of danger as pointed out by Crile, Bloodgood, McCallum, Dawbarn, and others, and the amount and rapidity of administration, the alkalinity, temperature and contra indications should be carefully considered in each case.

4. Its administration should not be preceded by stimulation by strychnine either in hemorrhage or shock, for it has been demonstrated that in hemorrhage where the blood pressure has been reduced to the minimum and strychnine has been administered, that convulsions and a lethal effect from the strychnine has occurred as soon as the blood pressure was raised, and in shock the use of strychnine is contra indicated at all times.

DISCUSSION.

Dr. Gray:—I was glad to hear the doctor's paper. I think he has pretty thoroughly covered the ground. I wish to emphasize some of the points that he brought out in the paper. I have had some considerable experience in salt solution and have been impressed with the idea that possibly some harm might be done by the injection. If the injection, (venous) be done with too low a temperature, it might be followed by a chill, followed by a profuse perspiration, and the good effects of the salt solution is lost. As the doctor states: If the intravenous injection is used, the higher temperature should be used—that is, up above 110 degrees, in some cases considerably higher. I have not been very successful with the continuous bowel irrigation with the salt solution. You have to gauge the amount of solution to such a nicety that I have found it rather difficult. A little too much solution will cause an irritability of the bowel. I have relied lately simply upon frequent salt enemas—say 10, 12 or 15 ounces of salt solution per rectum given every hour, or such a matter. As the doctor has stated in his paper, this condition of shock is not due to actual loss of blood.

Dr. Carmichael:—I wish to thank the ladies and gentlemen for their courteous attention and the doctor for his kindly discussion.

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Proper Vaccination is less dangerous than accidental skin scratches.

TREATMENT OF PERIANAL AND PERIRECTAL ABSCESSES.

With report of cases.

By E. H. THRAILKILL, M. D., Professor of Rectal Surgery in Medical Department University of Kansas, 307 Rialto Building, Kansas City, Mo.

In choosing a subject for this society, it was my aim to present one which would be of interest to the general practitioner and surgeons; hence I will consider the treatment of perianal and perirectal abscesses.

Knowing as we do, that a large percentage, if not the majority of fistula in ano are due to abscesses, should prompt us to appreciate the importance of an early and radical operation for all of these conditions, even before pus has formed, and thereby reduce the number of fistula in ano. If these abscesses received the surgical attention they so justly demand, fistula would not enter into our statistic table in such astonishing numbers. A very important anatomical fact we should not overlook is the proximity of these abscesses to the peritoneal cavity. In fact this cavity has been opened in operation for abscesses in this location. Then, owing to this fact, this apparently minor operation may become a major operation, and terminate fatally. In considering these abscesses, I recall the old time honored adage: "procrastination is the thief of time." While we are procrastinating the operation by using palliative treatment, the pus, etc., steals its way into other cavities or into deeper structures, thereby complicating matters, lessening the chances for recovery and making the prognosis uncertain.

Abscess of the rectum is a comparatively frequent occurrence. This is due to the physiological sluggish blood stream, the peculiar loose arrangement of the tissue in this region, and the large number of lymphatics and the ease with which septic material is carried from an abrasion of the filthy mucous surface or perianal surface. The majority of the chronic abscesses of the rectum are due to a suppuration of tubercular deposits. This subject I will not enter into.

In all operations near the anal orifice, as much or more antiseptic precaution should be employed as elsewhere. But owing to the intense pain elicited from manipulating these abscesses, it is almost impossible to scrub and make them aseptic without a general anesthetic. Before entering upon the treatment I wish to remind

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you of one important feature, i. e., have we an abscess or a blind internal fistula, with a pocket of pus with which to deal. If the latter exists, the symptoms are very similar, treatment very different. Palliative treatment offers very little benefit in the treatment of furuncles or abscesses except to alleviate pain. Operative interference is the only treatment which we can promise as a rapid and permanent cure. I quote the following from Binnie's most excellent manual of operative surgery: "Acute abscesses ought to be drained as early as possible; the operation should be performed under aseptic precautions. This is important because of the danger of carrying increased or mixed infection. For example, grafting a streptococic on to a staphy lococcic infection."

To take up the treatment of perianal and perirectal abscesses intelligently, I feel it my duty to classify them and consider each individually. I prefer Tuttle's classification, which is as follows:

CIRCUMSCRIBED INFLAMMATION OR ABSCESES.

Superficial. 1, tegumentary. 2, subtegumentary. 3, ischio rectal.

Profound. 1, retro-rectal; 2, superior pelvi-rectal; 3, interstitial.

Diffused Inflammation: 1, diffused peri-rectal cellulitis; 2, gangrenous peri-rectal cellulitis.

The tegumentary or follicular abscesses are simply pimples or furuncles around the anus due to an infection of the follicles or glands in this locality. The treatment I pursue is to make them aseptic, incise them freely, and have patient use an ointment composed of a 50 per cent solution of ichthyol in lanoline.

Sub-tegumentary abscesses. These are usually due to an infection carried from an abrasion of the skin to the sub-cutaneous tissue. As this is a circumscribed inflammation below the skin, more care is required in the treatment. After the patient is prepared as above given, a local anesthetic is employed. Then with a straight bistoury an incision should be made the full length of the abscessed cavity. Owing to the fact that these are single (monocular) they are easily drained and irrigated. If the cavity is very deep, I pack with gauze, and cover this with gauze saturated with a 5 per cent solution of carbolic acid and irrigate at least once a day. Sometimes these cavities are so shallow, that it is with difficulty that we can keep the packing in its place. Immediately after evacuating the pus, the sphincters should be dilated as thoroughly as possible; keep the patient in his room for a few days, and the

bowels confined during this time, and the chances for a rapid and permanent recovery are good.

Ischio-rectal abscesses. For the benefit of those who are not familiar with the anatomy of these fossae, and to enable me to give the treatment more intelligently, I will briefly review their anatomy. They are wedged shaped spaces located between end of the rectum and the tubes ischii, and are found back of the perineal spaces. The base is directed downward, resting upon the superficial fascia and skin. Each space is bounded above by the levator ani muscle, and externally by the obdurator fascia, the obdurator and internus muscles, the ischii and the sacro-iliac ligament. Posteriorly, by the coccyx. They measure before backward, two to three inches; laterally one to one and three-eighth inches; vertically one and one-half to four inches. Of course these measurements will depend upon the size of the subject.

These fossae are filled with adipose and cellular tissue, through which ramify hemorrhoidal vessels, nerves and lymphatics. They are divided into a number of compartments by connective and cellular tissue bands, and communicate with each other through the lymphatics and blood vessels. Owing to the division of these spaces into compartments the operator sometimes has a multiple abscess with which to deal.

In operation upon ischio-rectal abscesses, a general anesthetic is sometimes necessary, and care should be exercised in the manipulation of these abscesses. Also try to avoid severing the sphincter muscles and it goes without saying that in all of these abscesses the external incision should be wider than the widest portion of the induration or abscess. After the pus has escaped, the finger should be introduced and a search made for other pockets; also destroy all connective tissue bands and remove all diseased tissue. This should be done under an irrigation of hot, sterile water, solution of boric acid, or saline solution, or bichloride of mercury. I usually dilate sphincters thoroughly, pack firmly the cavity for the first treatment, for fear of subsequent hemorrhage.

If an abscess of a fossa is allowed to take an uninterrupted course, it will sometimes extend to the other fossa or both sides may be involved simultaneously becoming connected through the little space between the aponeurosis of the levator ani muscle and the external sphincter.

The operation for a bilateral ischio rectal abscess is to make an incision between anus and coccyx, extending either end of the incision into the fossae on either side, and use the same dressing as in a unilateral abscess.

In the profound type of abscesses, viz., retro rectal, or superior pelvi rectal, or interstitial, careful dissection should be made to the pus and the finger introduced and all diseased tissue broken down, and the cavity irrigated with hot sterilized solution. An incision to reach a superior pelvi rectal abscess should be made along the side of the rectum. To reach a retro-rectal abscess, an incision should be made between anus and coccyx extending upward to abscess.

To reach an abscess between the prostate gland and rectum, an incision may be made through the perineum in front of anus and the abscess and reached through blunt dissection. In abscess of the upper rectum, all are best drained with drainage tubes instead of gauze and irrigated through the tube.

The dressings are the same as in the Ischio-rectal variety. The patient should be kept in bed for several days, and placed on the best of nourishment. In the treatment of tubercular abscesses I evacuate the pus, irrigate the cavity with hot bi-chloride solution and fill cavity with the iodoform emulsion. I give them their freedom as soon as they are able to walk. Plenty of sunshine and force feed them. In the early stages of abscess formation a diagnosis is sometimes difficult to make. When made, operative intervention should be instituted at once.

Case No. 1. Mrs. G., white, age 53. Complained of pain to left of rectum extending up toward tube and ovary. She grew rapidly worse and was compelled to send for her physician, who called and (without an examination) made a diagnosis of abscess of the "tube ovary or rectum," and prescribed antiphlogistine.

The next day found her considerably worse. Her physician called and prescribed antikamnia. At the request of the patient he made an examination and found her suffering from a peri-rectal abscess.

The following day she suffered intense pain. Nothing would relieve her but large doses of morphia sulphate, hyperdermatically administered. Her physician thought it better to "let nature take care of it as do not believe in using the knife, and hope it will break externally". Of course the pus burrowed in the direction of the least resistance finding its way into the vagina, whereupon she was somewhat relieved of her pain. He then prescribed flax-seed poultices to take the place of the "Denver mud." Within a few days it opened just within the rectum establishing a recto-vaginal fistula.

Later she came to Kansas City and consulted Dr. Chas. Lester,

who referred her to me. The fistulous tract was dissected out and the wound closed with deep sutures getting union by first intention.

She was able to return home in about three weeks with restoration of the parts.

Case No. 2. Mr. B., white, age 71, farmer. Complained of pain in rectum and sent for his physician, who made a diagnosis of hemorrhoids and prescribed accordingly. At a subsequent visit he made an examination and found patient suffering from an abscess of the rectum (ischio-rectal). His treatment now consisted of anti-phlogistine and opium suppositories. He was another who "did not believe in the knife, and allowed nature to take care of it." The pus finally found its way into the rectum leaving a large pocket of pus. (a blind internal fistula).

He was treated three weeks for this trouble after which he was sent to me. The poor fellow was in bad condition, very weak and nervous, temperature 101, pulse 108, anorexia, and in constant pain.

I made a free incision through abscess wall, cutting through both sphincters dissected out all diseased tissue and allowed it to heal by granulation. Put him on the best of nourishment and he was well and able to return to his home in three weeks.

Summary. A physician should never take a patient's diagnosis for a disease of the rectum. But examine him thoroughly before treatment is instituted.

(b) As much antiseptic precaution should be employed here as in surgery on other parts of the body.

(c) A straight bistoury is preferable to a curved one, because the surgeon can be more certain as to the exact location of its point.

(d) The incision should be wider than the widest portion of the induration or abscess.

(f) A curette should never be used in cleaning out these abscess cavities owing to the danger of opening up a new field for bacterial invasion.

(g) The abscess cavity should be packed firmly in the first dressing to prevent subsequent hemorrhage.

(h) The patient should be kept on the best of nourishment and allowed the freedom of his room as early as possible.

COUGH.

By WM. F. SAWHILL, M. D., Concordia, Kansas.

We all know a cough when we hear it, but to define the mechanism is somewhat difficult. I do not think it necessary, however, to further than state that a cough is a forcible expulsion of air from the bronchial tubes or may be a succession of such efforts. These efforts are as a rule to remove some substance that is obstructing or irritating the air passages; or the cough may be reflex. In producing the cough the triangularis sterni and the abdominal muscles are the power. Anything that will cause an irritation of the peripheral expansion of the pneumogastric nerve or of its connections that is to irritate the afferent nerve fibres causes impulses to be transmitted to the medulla, to its respiratory center and as in the case of all nerve irritation carried out through the efferent fibres; this is more or less of a reflex action.

These reflex actions are not always to be controlled, and may cause serious mischief sometimes. A good example of reflex cough is that caused by irritation of the auditory meatus. Other examples of reflex cough are when it is caused by disturbances of the digestive tract, nasal passages or disease of the uterus or ovary or by pressure on the nerve by an aneurism. There is the suppressed cough such as is found in pleurisy or pleurodynia with bronchitis. The muffled cough is due to disease of the vocal cords and is a serious symptom, usually heard in laryngeal diphtheria; it is also heard in tuberculosis of the larynx.

We often hear the hard, dry, metallic cough of dry bronchitis, and the spasmodic cough of whooping cough.

Cough is a result of some disease of the bronchial tubes or lungs in nearly every case. It is not the cause, but the effect of disease. Reflex coughs depend on some irritation of another part of the body.

I do not want to take any further time of this society by going over a subject with which you are all acquainted, more than to outline it; but will call your attention to the treatment of cough and to two or three points especially.

Our text books usually say to remove the cause, but often the cause cannot be removed. The disease causing the cough may be incurable. In every disease accompanied by a cough the cough is

annoying, often aggravating the disease, as in whooping cough or the cough of phthisis. In both these diseases the cough is often more severe than necessary, exhausting the patient and lowering the vitality. In incipient cases of consumption where we succeed in quieting the cough the patient always improves and the chances for recovery are better.

It is a fact that physicians are careless in prescribing cough remedies. In the dispensaries they prescribe by number and it matters little the character of the cough, he gets No. 1 or No. 2 cough remedy. A cough remedy should be made as palatable as possible. Do not give nauseating mixtures if it can be avoided. I make a true statement when I say that nearly every physician has one or two favorite cough remedies and he gets the habit of prescribing them in nearly every case. It is not a good practice to stop a cough in phthisis, but modify it all you can and finally stop it if possible, and in all other cases stop the cough if you can do so.

In acute cases encourage expectoration. The name of the cough remedies is legion, but after casting out in each individual case those not suitable we do not have many left. This brings me to the two or three points I want to make in this paper. First, in acute cases we get better results if we use an oil in our cough mixtures. Put a few drops of sweet oil in your nose and note the flow. One writer cautions against giving an infant with bronchitis castor oil, as it may be dangerous, filling up the small tubes of the lungs with too much secretion. It has been demonstrated that linseed oil has an affinity for the bronchial mucous membrane to a remarkable extent, and is entitled to be classed with the expectorants. There is probably no remedy that will liquify the secretion in acute bronchitis or bronchial asthma and bring about as prompt relief as linseed oil. It can be given in an emulsion with some sedatives added like morphine in small doses and hydrocyanic acid.

Second. In the treatment of chronic cough first disinfect. There is a perverted or abnormal secretion in all chronic bronchial discharges that acts as an irritant and causes cough. The normal secretion from the bronchial mucous membrane does not contain much mucous; it is an aqueous slightly saline fluid with only enough mucous to diffuse it over the surface. Much mucous indicates an abnormal secretion. To get rid of the mucous is the object of treatment.

The third point to which I want to call your attention is this: make your cough mixtures alkaline. I think the most useful cough remedy I have used is a simple mixture of dilute hydrocyanic acid,

1 m to the dose, with a very small dose of morphine in syrup of wild cherry and water to which is added one-half dram of bicarbonate of potash to the ounce. This will promptly relieve in most chronic coughs, especially in phthisis. My attention was first called to the alkaline part of the remedy by knowing of a severe case of obstinate coughing to be cured by the patient taking small doses of soda bicarb frequently during the day, and experience has proved to me that an alkaline cough mixture is the better remedy.

DISCUSSIONS.

Dr. Johnson, Coffeyville:—There are a few things along the line of reflex cough which occur to me, which I think the doctor failed to mention. We find the cause of the reflex cough (as he has mentioned) in the ear many times from impacted ear wax; or, you may have it from a tonsil with opening crypts. Sometimes from a case that emanates from it, you may have a cough that resembles a consumptive cough. Then again, the uvula (as small as it is) may make you think that you have a consumptive cough. I have had patients come in many times, thinking they had consumption, and by cutting off the uvula, the cough disappeared. A reflex cough can easily be removed by removing the cause.

Dr. Sawhill:—I wish to thank the doctor for his remarks; and, to repeat one thing: In acute cases you will find that the use of oil usually brings prompt relief.

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The Great American Fraud.—In his latest article in Collier's Weekly Samuel Hopkins Adams deals with nostrum advertisements in the religious press, and does not hesitate to arraign the corruption found in high places.

"Religious journalism," says Mr. Adams, "props one corner of the tottering Great American Fraud." He calls attention to the fact that there are a number of religious journals of different denominations that are free from objectionable advertisements and names others that are engaged in clearing their respective pages of fraudulent or dangerous patent medicines. Others preach editorially a continuance of the "golden rule" but advertise the "golden brick." A few religious papers open their editorial columns to reading notices of quacks. Any one who wishes may buy the space and have editorials written in recommendation of certain "cures." One journal in refusing the advertisement of Duffy's Malt Whiskey suggests that the manufacturer call it Duffy's Malt or Duffy's Malt Remedy, stating that as long as the word whiskey was used the advertisement could not be admitted to its columns. That the preparation, with murderous mendacity, claims to cure tuberculosis and pneumonia makes no difference to their eagerness for a share of its earnings. The reek of blood itself will not revolt them, but the smell of alcohol sends up their hands in holy horror.

NAIL INJURIES TO THE EYE.

By JAMES W. MAY, M. D., Kansas City, Kansas.

This paper is simply a recital of a few cases occurring in my private practice, and they have not been selected because of especially good results obtained, but simply as an argument for conservatism in this class of accidental cases. Of course I do not mean by conservatism to let an eye remain when it is apparent that sympathetic inflammation is about to develop in the uninjured eye. The line between sympathetic irritation and sympathetic inflammation must be severely drawn, otherwise eyes that should remain will be enucleated and vice versa. We all know that when sympathetic inflammation once sets in it usually ends in blindness or greatly diminished vision, therefore it is obviously important that we recognize the danger and avert the wreck. As to the actual cause of sympathetic ophthalmia we are much in the dark, various theories being advanced, but none proven. Sympathetic irritation nearly always precedes sympathetic inflammation, and is the danger signal, but not the wreck. In the former there is an irritation in the sympathizing eye, which is evinced by undue sensitiveness to the light, increased lachrynation with speedy tiring of accommodation, thus producing inability to do near work for more than a few minutes. The exciting eye presents marked peri corneal and ciliary injections and marked tenderness in ciliary region. If the symptoms just mentioned will not clear up in a short time with energetic treatment, and the offending eye continues to present inflammatory changes, then in my opinion it should be immediately removed. In such cases, it may be asserted positively that the sympathetic irritation will be relieved by the operation and that usually no bad consequences will follow the operation. Another question which often arises when both eyes have been severely injured, and that is, which eye shall be removed? Here conservatism must again be urged, for the eye which at first seems hopeless may in the end be the best. This is especially true with injuries involving the lens. Here the wound may heal, the lens be absorbed or afterward extracted and an eye with fair vision result, whereas, an insignificant puncture through the sclera into the vitreous which has not affected vision to the slightest degree, may by infection destroy the eye in a very short time. This is especially true of the last

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named cases for the vitreous has low resisting power to infection, which once started ends in total destruction of the eye. I have never seen sympathetic ophthalmia develop in less than four weeks, and I have some doubts as to whether it can be produced sooner, although some authors declare that three weeks or less may bring it about. However, it matters little how severe an eye is injured it is at least perfectly safe to let it remain two weeks and in that time changes may occur that will make a decision relative to its removal without question. Another point I wish to make is this, at this day and age, with all of the modern methods and equipment in one's armamentarium, we are very prone to overtreat cases. Especially is this true with injuries to the eye where the idea to do something radical strongly suggests itself.

I will briefly give you the history of the cases before you, and you can then make an examination. I will say that these cases are not unusual results obtained, but simply reminders of what conservatism, and incidentally nature, will do when given an opportunity.

Case 1. Mr. C., age 40, while at work in a local packing plant, January 12, 1904, was struck in the eye by a part of a rusty ten penny nail. The part containing the head made a large opening in the cornea extending from the center of the cornea past the sclero corneal margin. He was almost wild from pain and when he recovered sufficiently pulled the nail from the interior of his eye. I saw him less than two hours after the accident and he was almost in a state of nervous collapse. The edge of the wound was covered with debris from the rusty nail, the anterior chamber was partially filled with blood, the iris torn to its root and lens opaque. There was, of course, considerable congestion and intense photophobia. He was sent at once to Bethany Hospital. The debris was cleaned away and the edge of the wound cauterized with pure carbolic acid. The eye flushed with bichloride solution, 1 to 5000, and atropia four grains to the ounce was instilled every two hours. The patient was put to bed and kept there. Ice cold applications were applied for twenty minutes every two hours. The next morning there was a muco purulent discharge which rapidly changed to purulent. The iris became firmly bound down to the lens its entire circumference and to this fact alone I attribute the saving of the sightless eye, for if the pus had entered the vitreous, enucleation would have been necessary in short order. The above treatment was kept up except the atropia was discontinued. In addition the corneal wound was kept open daily and thin strips of iodoform jelly were introduced into the anterior chamber. This latter treatment was

of no benefit whatever, and I have only condemnation for it. The cold compresses were changed to hot and the same treatment practically continued throughout the case. The discharge ceased the fourteenth day and the cornea healed, leaving his eye in the condition you now see him, viz., the iris drawn entirely across the upillary space and a large white fan shaped scar extending from the center of the cornea to the sclero-corneal margin. On more than one occasion he presented sympathetic irritation in his good eye, but I refrained from enucleating the offending eye and the irritation subsided in a few hours. The result in this case is far better than to have enucleated for the reason he has a fairly good looking eye with light perception and it might be possible to give him some vision by an iridectomy. However, I would be loath to operate upon his eye for the reason that it might start up the old inflammatory process which would end in the total destruction of the eye. If he would lose his good eye from any cause, an operation on the bad one would then be advisable.

Case 2, Mr. F. R., age 30, carpenter, on January 6, 1905, was struck in the left eye by a nail, which entered the anterior chamber, making a tear in the cornea about $\frac{1}{8}$ of an inch long extending from the margin of the iris toward its root. The head of the nail entered the anterior chamber and was extracted by the patient. Fortunately the lens remained uninjured. I saw the patient a few hours after the accident and found him suffering considerable pain. The iris was torn and there was considerable pericorneal redness. There was some blood in anterior chamber. The edge of the wound was cauterized with carbolic acid and he was treated throughout the case with atropia four grains to the ounce and flushing with bichloride solution 1 to 5000. Ice cold compresses were used to control the inflammation. His condition as you now see him presents a small anterior synechia which was impossible to prevent and a small scar which does not interfere with vision to any great extent. With a -.50 cylinder axis 180 he has 20-20 or normal vision.

Case 3, Mr. A. B., age 31, carpenter, on January 10, 1906, was struck in the left eye by a nail which entered the cornea about the lower margin of the iris and made a tear in the cornea about $\frac{1}{8}$ of an inch long, entered the anterior chamber tearing the iris $\frac{1}{8}$ of an inch along its root. I saw him at Bethany Hospital within three hours after the accident occurred. The anterior chamber was partially filled with blood and the torn iris prolapsed through the wound. He had been working with tar paper and he was cov-

ered with dirt, his eye contained a large share. He was scrubbed up, put on the operating table and the prolapsed iris excised. The eye flushed with bichloride solution 1 to 5000 and atropia four grains to the ounce instilled. Ice cold compresses were used throughout to keep down swelling and inflammation. He was put to bed and kept there until the corneal wound healed. A muco-purulent discharge appeared the next morning and disappeared in 48 hours after using a 25 per cent. solution of argyrol. He made an uninterrupted recovery, and was at work in three weeks. The result in this case shows the iris at its margin adherent to the cornea in one place and he has an irregular pupil owing to the excised iris and also where the iris is torn from its root. The scar has contracted and does not interfere much with vision which is 20-40 with a 1.00 cylinder axis 180. He can also see to read ordinary print.

Case 4. Paul M., age 16, on April 14, 1906 while at work in his father's printing shop was struck in the left eye by a nail, which tore the cornea about $\frac{1}{4}$ inch commencing at almost the center of the cornea and extending outward and downward. The lens capsule was ruptured and the lens considerably lacerated. The iris was not prolapsed. The nail dropped out after doing the injury. He was sent at once to Bethany Hospital, put to bed and the following treatment instituted: Ice cold compresses for twenty minutes every two hours followed by a flushing of bichloride solution 1 to 5000 and one drop of atropia four grains to the ounce. There was not much pain, but a great deal of peri-corneal congestion. Swelling of the lens took place immediately. There was no discharge. His condition now is as follows: The lens has partially been absorbed and a needling operation will probably be performed in the near future. There is a slight anterior synechia. His vision is 7-200 with a plus 6.00 sphere and will be much better after the balance of the lens has been removed. He has slight deviation outward due to inability to use his eye which I think will be corrected when vision becomes sufficient for him to use it. On two or three occasions he presented symptoms of sympathetic irritation which would clear up in a few hours. There is considerable yet to accomplish in this case. References: Norris & Olliver, Ophthalmology; Jackson, Ophthalmology.

DISCUSSION.

Dr Jarrett:—I was very glad to see the stand which Dr. May took about conservatism in this class of injuries. I know they used to teach that if the eye is entered and infected in the interior, it should be removed immediately; and, the sooner the better. I believe many eyes may be

saved. If we can only save the form of the eye, even then it is better than an artificial eye. I had a rather interesting case some two or three years ago. A man had a nail injury—the nail had penetrated the sclera, went into the interior of the eye. We had the usual symptoms; treated the eye. He made a good recovery; but, this last spring he had a recurrence of the trouble. It was so bad that he thought it was necessary to come to me. I used a few drops of atropin, and nothing more was necessary. I do not know that it ever will be. There is one thing that I want to emphasize in eye trouble—that is, let the patient know the gravity of the case. Let the patient know the danger; and, let him have the responsibility of deciding about the operation. I do not tell a patient that I am going to save the eye. I give him to understand that we will do the best we can for him. Advise him that perhaps it would be safer thing to remove the injured eye for the sake of the uninjured; but let him assume the responsibility.

Dr. Hayes:—I wish to say a few words on the item of the application of ice to the eye. That opens a very large question. Is it best to do that? Is it of any value save for the purpose of diminishing pain and discomfort? That is the only reason I could conceive of it. The general principle involved is: Is it ever the best thing to apply to any organ or tissue any kind of treatment that would injure healthy tissue?

Dr. May:—I wish to thank the society for the kindly way in which they have received the paper. I have not much to say in closing. I will simply answer Dr. Hayes' question. I never use ice directly applied to the eye as it injures the cornea; but ice cold applications keep down the pain and inflammation, and I have found them much more beneficial than heat.

Dr. Bolton:—Is it not true that the age of the patient has a great deal to do with the benefits of hot or cold applications?

Dr. May:—I have never found any difference. It might be that in some cases hot would be better; but in the same class of cases, I should use cold applications regardless of the age of the patient.

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MORPHIA AND CACTIN COMPOUND.

By V. E. LAWRENCE, M. D., Ottawa, Kansas.

For some six months past "The American Journal of Clinical Medicine" has been presenting to the profession the morphia and cactin comp. It consists of hyoscine hydrobromide 1-100 gr., morphine sulphate $\frac{1}{4}$ gr., cactin 1.67 gr. in hypodermic tablet form. It is a new hypnotic and anesthetic.

It has rapidly taken hold of the doctors. If the reports of those who have used it are to be relied upon we at last have a means of

removing pain and producing sleep which is reliable, safe and unobjectionable.

Reports are coming in from all parts of the United States. Surgeons and hospitals of experience and note are using it in their largest operations. Lanphear of St. Louis has used it instead of ether and chloroform in three or four hundred capital operations, such as abdominal operations, amputations at the hip joint, etc. Some of these operations required two hours time.

While reading reports of its use with more than usual interest I have been somewhat slow in using it in my own practice. We all know the objections to the use of chloroform and ether as anesthetics, and we would all be glad to find an unobjectionable substitute. I finally concluded to try it in obstetrics and sent to the Abbott people for a small supply. Since then I have used it in three cases. In doing so I have followed Dr. Abbott's advice and injected but one-half of one tablet. The results have been very gratifying. The pain is relieved, the patient falls asleep between pains, the child is born with much less than the usual amount of pain. After all is over the patient falls asleep for about one hour and expresses the belief that she never before had so easy a time.

I have not in obstetrical cases used more than one-half a full tablet because of its hypnotic effect upon the child. In my cases the children showed nothing more than a desire to fall asleep, and because of the child, I would not advise using more than the above dose unless the case were a tedious one and enough time had elapsed to allow a repetition of the one-half dose.

But for surgery, dentistry, the passage of gall and kidney stones, gastralgia, neuralgia and painful affections of any kind it should be used in full dose and repeated as needed to allay pain and produce sleep.

In surgery it is recommended that the first tablet be injected into the arm one and one-half hours before operation is begun, then one more twenty minutes before operation is begun. If the patient then responds to the pain of operation ten drops of chloroform or ether may be used to complete the anesthesia, although this is not often needed. In addition some have injected one-half tablet. Under these doses the patient is usually prepared for a one or two hours operation with a five or six hours comfortable sleep afterwards.

In the several thousand cases of its use already reported there has been almost unanimous satisfaction of its use reported. I think only two or three have used it in too large doses for the safety of

the infant. I would suggest that should the infant become unduly narcotized that a teaspoonful or two of strong coffee would be a suitable antidote.

One writer predicts that its use is about to revolutionize the field of anesthetics and that it will so reduce the agony of child birth as to thereby materially increase the birth rate.

It has been successfully used for the extraction of teeth. I know of two cases where it was so used. But one tablet was used in each case. In one fourteen teeth were extracted without suffering and in the other sixteen were extracted with like result. One doctor reports a case in which a mouthful of teeth were extracted and the patient was unaware of their removal for two hours after.

I should mention here that under full anesthesia the respiration sometimes drops to six or eight per minute but pulse is good and these patients have safely returned to consciousness after several hours sleep.

I last used it in an operation for internal hemorrhoids. Two tablets were used. Three piles were tied and one removed with the scissors. The parts were extremely sensitive. The patient slept for three hours after and then awoke saying she was entirely comfortable and that while she realized that the operation was going on there was almost no sensation.

From what I have seen and read of this new anesthetic I am inclined to the belief that it is about the most important addition to medical and surgical practice which has fallen into the hands of the doctors in many years past.

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Report of the Meeting of the Council of Medical Education at Chicago.

By M. F. JARRETT, M. D., Delegate, Ft. Scott.

Before proceeding to make a report of the last meeting of the Council on Medical Education, I think it may be well to state to you briefly, what this council is, and for what purpose it was created.

When the American Medical Association was re-organized, this Council on Medical Education was appointed with the idea of bringing about a better feeling and co-operation among the states, so

Report made to House of Delegates of the Kansas Medical Society, Kansas City, May 10, 1907.

that we could improve not only the medical teaching of the country, but that we could improve the personnel of the medical profession in America. The science of medicine as now taught, is vastly different from what it was a quarter of a century ago. In order to graduate in medicine now a student should have a better preliminary education before he is allowed to matriculate in a medical college, than was required of the students of medicine even 15 or 20 years ago. The requirements for admission to all medical colleges at that time, were low, and in the majority of schools then the student who had the price of tuition had no difficulty in gaining admission if he could read, write and cipher. The result was that many men were graduated as M. D.'s who did not have even the rudiments of an ordinary education. This fact was not only painfully apparent to the better class of medical men, but it was also well-known among the laity. And it is the purpose and desire of this council to assist in unifying the requirements as to preliminary education in ALL the medical colleges of the United States. It has no authority to establish standards, nor to say what the requirements shall be, in any case. Its functions, therefore, are only of an advisory nature.

The Council on Medical Education has had three annual meetings, the first being held in Portland, and the last two in Chicago. The meeting next year, will also be held in Chicago. The membership is mostly composed of delegates from state examining boards, state medical societies, government medical societies, colleges of liberal arts, and other educational organizations. The attendance this year was about 100 delegates, and the meeting was held in the parlor of the Auditorium Hotel in Chicago.

Dr. Arthur Dean Bevan of Chicago, is the chairman, and Dr. N. P. Colwell of Chicago is the secretary. The four vice-presidents are Dr. W. T. Councilman, Boston; Dr. J. A. Witherspoon, Nashville; Dr. Charles H. Frazier, Philadelphia, and Dr. Victor C. Vaughan, Ann Arbor. I think the organization is a permanent one, and the chairman in his opening address this year strongly urged the attendance of the same delegates each year, for the reason that they are more or less acquainted with the objects, aims and purposes of the organization, and the greatest hindrance in the work so far, he said, had been the changing of the delegates each year.

The meeting was called to order by the chairman, Dr. Bevan, who first made a brief address of welcome to the delegates, and then read his formal address. He reviewed the work which has

been done by the various committees since the meeting last year, showing that a great deal of effective work has been done. Probably the most important work was that done by the committee appointed to visit the various medical colleges in the United States, and to note their equipment, the requirements as to preliminary education of their matriculates; the length of term, and the nature and character of the work done in each school. He gave the name and location of each medical school visited with the recommendation of the committee, concerning it. The schools were grouped into three classes. Those graded above 70 were considered first class, those from 50 to 70 were below the standard of first class in equipment and in the nature of the work done, and should make improvement or unite with some stronger school; and those graded below 50 were found to be so far below the general requirements that it was advised that they should be discontinued. The publication of this report was not deemed advisable at the present time, although the name and grade of each college was read to those present.

After investigation of the 160 medical colleges the committee recommended as follows: 81 were graded above 70, which places them in the front rank, and means that their equipment was considered satisfactory, and their work first class; 46 were rated from 50 to 70, showing that the committee considered their work as being unsatisfactory, and should be improved in order to comply with up-to-date standards; and the remaining 33 were so poor in equipment and character of their work that it was recommended that state examining boards should not recognize their diplomas as being of any value.

Following this, were the reports of the secretary, and the various committees, which occupied all of the morning. In the afternoon several papers pertaining to medical education were read and discussed, and addresses were given, each one, almost without an exception, being very interesting. I shall not try to mention all of them. The general trend of the arguments was to the effect that there are too many medical colleges in this country and that they are turning out too many incompetent graduates as M. D.'s. The chairman said that there are about 160 medical colleges now in the United States, and that there should not be more than 100. Another delegate made this statement: "There are on an average 4000 doctors graduated every year, by the medical colleges of the country, and about $\frac{3}{4}$ of these are utterly incompetent, and should never be permitted to practice medicine. Certain medical colleges

are lacking in proper equipment, the instructors are wanting in the necessary ability for their task, and their examinations and methods are useless." This condition, it was stated, is caused largely by the small medical colleges, which are owned and conducted by private corporations or individuals, and not having the necessary endowments are poorly equipped, but they must turn out their graduates each year, in order to make the institution pay. State ownership of medical colleges, was the remedy suggested as the only feasible one, unless the colleges can secure liberal endowments. It was argued by several, that if a state owns a medical college, it can erect the necessary buildings and properly equip them, and as such institutions are not dependent upon the tuition for their subsistence, that better and more thorough instruction will be given than can be had in the private schools with poor equipment.

Concerning the requirements that should be exacted from those desiring to become students of medicine, it was generally agreed that the possession of a high school diploma should not be considered as evidence of sufficient preliminary education. The Chancellor of Vanderbilt University, Nashville, said that if the requirements were placed higher, and the degree of "A. B." or "A. M." should be required of each candidate for matriculation at medical colleges, that they had private institutions in the south which were turning out enough graduates in these degrees to fill all our medical colleges. And yet, he said, some of these graduates were so ignorant that they could scarcely spell their own names.

Other delegates from various parts of the country stated that similar conditions existed in their locality, evidently showing that this state of affairs is not peculiar to the south alone.

To remedy this unsatisfactory condition, it is suggested that an examination board be appointed in each state, say by the state superintendent of public instruction, and that before students shall receive their diplomas as graduates, they must pass the examination by this board, and that no member of this board shall be connected with a medical college. The requirements should be such an education as will admit the student to our recognized universities.

The council recommends the addition of a year between the high school course and the present four year course in the medical schools, and that this year be devoted to chemistry, physics, biology and languages. That this desirable advance is not far off is shown by the fact that a resolution embodying this provision, has just been unanimously adopted by the National Confederation of Examining Boards, at their meeting in Boston. It is probable that dur-

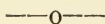
ing the year a number of state licensing boards will agree to this recommendation.

The length of time required to complete a medical education will soon be increased all over the country. Already 44 of the colleges which are doing the best work, have decided to add one or two years to their course. It is probable that after the year 1910, all students who begin the study of medicine will be required to put in five years in a medical college, with an additional year as an interne in a hospital.

After graduating from such an approved school, the student will be entitled to an examination by the state licensing board. If he passes the examination successfully he will be licensed to practice in that state.

The council strongly recommends the careful selection of competent men to serve as members of state licensing boards. They should be men of high character, skilled in their profession, and beyond the reach of any influence other than their own sense of duty. State medical societies should select such men, and recommend their appointment.

State reciprocity is making progress, and will soon become universal. Already several of the states have adopted it, and the others will soon follow.



SMOKE IN RELATION TO HEALTH.

A. Jacobi, New York City (Journal A. M. A., September 7), protests against the idea that the smoke question is one of social rather than sanitary importance, and quotes British and other statistics to show that diseases of the respiratory organs and their mortality have increased with the increase of the smoke nuisance in civilized communities. He quotes also experimental results of Aschoff, Schulze, Beitske and others as proving that anthracosis of the lungs is directly caused by inhalation, and he criticizes the New York sanitary code for its inefficiency as emasculated by judicial decisions, in the remedying of this evil.

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CHAS. S. HUFFMAN, EDITOR
J. E. SAWTELL, {
GEO. H. HOXIE, { ASSOCIATE EDITORS

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The National Associations of Military Surgeons will meet at Jamestown, October 15th to 18th, inclusive. Place of meeting will be at the Inside Inn. There will be representatives from nearly every government in the world. The membership includes the medical officers of the National Guard, Army, Navy, Marine, Hospital service—all officers whether on the active or retired list, are eligible to membership.

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HEADS OF THE DEPARTMENTS OF THE UNIVERSITY OF KANSAS.

In completing the organization of the clinical department of the school of medicine of the University of Kansas, the following gentlemen were elected, as heads of the departments:

Internal Medicine, Dr. Robert T. Sloan.

Neurology, Dr. H. O. Hanawalt.

Pediatrics, Dr. F. H. Weiss.

Surgery, Dr. J. F. Binnie.

Obstetrics, Dr. Geo. C. Mosher.

Economics and Jurisprudence, Dr. D. R. Porter.

Ophthalmology, Dr. John Thompson.

Rhinolaryngology, Dr. J. E. Sawtell.

The representatives to the council of the medical school (the body which has control of the matters pertaining to the entire school) are, as follows:

Internal Medicine, Dr. E. W. Schaufler.

Surgery, Dr. J. D. Griffith.

Gynecology, Dr. Geo. C. Mosher.

Specialties, Dr. J. E. Sawtell.

NEWS AND NOTES.

A Doctor a Sexual Pervert.—A young preaching evangelist recently died in Kansas City under such circumstances as to lead the coroner to hold an autopsy. He found the penis of the dead man to be mere gangrenous stump—with all the appearance of having been bitten off. The cause of death was apparently sepsis, although the attending physician had called it Bright's disease. The boy had been living with a Dr. Fraker for two years or more, in very intimate relationship. It seems that Dr. Fraker has always had a boy companion wherever he has been living, and has been proven guilty of an attempt to collect \$60,000 life insurance by disappearing under suspicion of drowning. A brother of the deceased is now with Dr. Fraker and the Humane Society and the police have been trying to get him away. Dr. Fraker is a member of the faculty of the Eclectic Medical University which recently moved from Kansas City, Missouri to Kansas City, Kansas.

The following letter has been sent out by Public Health and Marine Hospital service, relative to the spread of diseases by use of milk:

CIRCULAR LETTER.

Treasury Department, Bureau of Public Health and Marine-Hospital Service, Washington, August 28, 1907.

To State and Local Health Officers and Other Sanitarians:

In the study of the sanitary milk problem undertaken by this bureau at the direction of the Secretary of the Treasury and the President, it is desired to make a compilation of all authentic cases in which disease has been spread by milk. This will include cases where milk has been the undoubted means of carrying an infectious disease to one or more persons. Whereas, in the light of present knowledge, the greatest interest centers in cases of typhoid fever, diphtheria, and scarlet fever spread by this means, yet the report of other diseases carried in this way is also desired.

It is believed that although many epidemics caused by milk have been reported in the printed reports of boards of health and in the medical journals, a greater number known to medical men have not been so reported.

If you will co-operate by reporting to this bureau upon the enclosed form, or otherwise, any cases of disease or epidemics spread by milk of which you have knowledge, it will be greatly appreciated.

An addressed envelope, which will require no postage, is en-

closed for the return of any report you may make. Reports, to be of service, should be returned not later than October 15, 1907.

WALTER WYMAN, Surgeon-General.

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ABSTRACTS.

ATOXYL.

W. A. Puckner and A. H. Clark, (Journal A. M. A., Sept. 21), report the result of a chemical analysis of this substance made in the Chemical Laboratory of the American Medical Association, which showed it to contain 25.77 per cent. of arsenic, 7.97 sodium and 17.58 per cent. water of hydration. The percentages of arsenic in other published analyses are: In that of Forneau, 27.25, with 13.1 per cent. of water, and that of Bertheim, later accepted by Forneau, and by the manufacturers, 24.09, with 23.03 per cent. water of hydration. The variation in the amount of arsenic in the different analyses is probably due to difference in the amount of water. Calculations show that anhydrous atoxyl contains the theoretical amount of arsenic and sodium indicated by the formula $C_9H_4NH \cdot AsO \cdot OH \cdot ONa$. Atoxyl was introduced by the medical profession about five years ago as a new organic compound by which almost unlimited amounts of arsenic could be administered without toxic effects. It has been highly recommended in the treatment of trypanosomiasis and other conditions in which arsenic is indicated. Puckner and Clark give a comparison of the dosage of atoxyl and Fowler's solution which is of interest in this connection. Since atoxyl contains the arsenic as an arsenate, while in Fowler's solution it is present as an arsenite, the doses are compared by calculating the actual amount of elementary arsenic in each case. The average dosage of atoxyl is given as from 1 3 to 4-5 of a grain every other day, and the dose, it is stated, may be cautiously increased to as much as 3 grains daily. As Atoxyl contains 25 per cent. of arsenic, the average dose every other day would contain from 1-12 to 1-5 of a grain of arsenic, while the maximum daily dose, 3 grains, would contain $\frac{3}{4}$ of a grain. The average dose of Fowler's solution is 3 minims, three times a day, but it can be cautiously increased to a much larger amount: from 30 to 40 minims daily is not uncommon. Each minim of Fowler's solution contains approximately 1-133 of a grain of arsenic, and the average daily dose of 9 minims about 1-15 grain, while the maximum of 60 minims contains nearly 1-2 grain. While the manufacturers have been claiming that forty times as much arsenic can be given in atoxyl as in

other arsenic preparations, the recommended dose of atoxyl is but one and a half times as great in arsenic content as that of Fowler's solution.

MODERN HOSPITAL CONSTRUCTION.

W. Gilman Thompson, New York City (Journal A. M. A., September 21), says that the modern hospital idea implies that construction should be adapted to treatment and that the old notion of merely lodging the sick is obsolete. He points out what has been done in this country in reconstruction and readjustment of old hospitals and gives results of a summer spent in Europe in study of hospital construction, where, he says, some of the modern hospitals are structurally far ahead of anything in this country. Among the hospitals specially noticed and described are the Policlinico at Rome and the Virchow and Moabit hospitals of Berlin, which are considered by him as illustrating some of the most advanced ideas. He does not favor the sky-scraper hospital except for emergency cases in densely populated districts. The pavilion plan he considers much better. Among the desirable features detailed are small wards, day rooms, flat roofs, porches, and the necessary arrangements for light, ventilation, heating, etc., adapted to the climate, together with means for hydrotherapy, thermotherapy, mechanical treatment, inhalation methods, etc. The article is illustrated.

CACTUS GRANDIFLORUS AND CACTIN OR CACTINA.

R. A. Hatcher, New York City (Journal A. M. A., September 21), has experimented on frogs, rabbits, cats and dogs with cactin and cactina and gives the details of his experiments, as well as a view of the literature of these substances and of the plants from which they are derived. While certain of the cacti undoubtedly contain very active principles, and while it is possible that cactus grandiflorus may at times and under certain conditions contain a principle with a strychnin-like action, the cactina pillets of the Sul'tan Drug Company and the cardiac tonic of the Abbott Alkaloidal Company were found by him to be practically inert, even when given in doses hundreds and thousands of times as large as those recommended.

CALCIDIN (ABBOTT).

In a contribution from the Chemical Laboratory of the American Medical Association W. A. Puckner and A. H. Clark (Journal

A. M. A., September 7), discuss the product calcidin (Abbott). Because of the claim that this preparation produces effects entirely different from those of iodine in any other form and because of the vagueness of the statements regarding its composition it was considered of interest to determine its nature. From an analysis (given in full) made of a specimen bought in the open market it was concluded that calcidin is essentially a mixture of iodine, lime and corn starch. By comparison, two grains of calcidin (the full dose) contain a little less iodine than three minims of the official Lugol's solution. The analysis of calcidin tablets shows that they differ from that of calcidin (powder), as they are essentially tablets of calcium iodine. The claims of unique therapeutic properties are not borne out by the facts in the case, and the lesson is drawn that manufacturers who make extravagant claims for their products, and the products themselves, are to be viewed with suspicion.

—o—

POSTAL CARD GIVING NOTICE OF MEETING OF COUNTY SOCIETY.

Below is a fac-simile of a postal card sent out by Dr. G. C. Glynn, secretary of Allen county society. It is unique to say the least, and attractive.

PROGRAMME

PAPERS

THE CONDUCT OF LABOR CASES Dr. A. V. Lodge

THE DIAGNOSIS OF ABDOMINAL DIS. Garlinghouse

PERNICIOUS ANEMIA Dr. Dresbach

TO MAKE THIS THE BEST CO Soc IN
UNFINISHED BUSINESS.

THE STATE.

ANNOUNCEMENTS:

NEW NOTIFICATION CARD

REMARKS:

DEvised By—

Dr. GLYNN Sec.

AUTHOR

Dear Doctor:
The Allen County Medical Society
urges you to attend the next Regular
meeting at 10th Kansas.
Wednesday Sept 18th 1897
Day Date Hour
o'clock p.m.

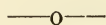
Iola, Kansas, Sept 17 1907

OBITUARY.**DEATH OF DR. HENRY O'DONNELL.**

Dr. Henry O'Donnell of Ellsworth, Kansas, died at St. Margaret's Hospital, August 23, 1907. He was 43 years of age. Dr. O'Donnell was born in Claire County, Ireland, October 27, 1864. He was the eldest of a family of eleven children. He was educated in Ireland, and there received the degree of B. A. He also studied medicine in the Royal University of Dublin. In 1884 he came to Ellsworth where his parents and his own family still live. He graduated from the Bellevue Hospital Medical College class of 1891. In 1891 he was united in marriage to Miss Jessie Kenninger and three sons and a daughter have been born to them.

He was a successful physician and surgeon and business man being prominently identified in everything for the advancement of his home town, county and state. He was surgeon general of the state during the administrations of Governors Stanley and Bailey. He was representative in the state legislature in 1901 and 1903. He is best known perhaps as being the author of the present law governing the practice of medicine in this state which is known as the Medical Practice Act of 1901.

He was a member of the Kansas Medical Society and the American Medical Association. In his death the medical profession of Kansas loses one of its most earnest workers, and one who gave his best efforts for the advancement of the profession. We extend to the family in their sorrow the heartfelt sympathy of the profession of Kansas.

**SOCIETY MEETING.**

The Southeast Kansas District Medical Society will meet at Parsons, October 15. Dr. G. H. Hoxie, dean of the School of Medicine of the University of Kansas, will deliver an address. There will also be an address by Dr. L. L. Uhles, superintendent of the State Hospital at Osawatomie, in addition to the regular program. Place of meeting will be at the Elks club rooms.

BOOK REVIEW.**BIOGRAPHY OF THE LATE NATHAN SMITH DAVIS, A. M.,
M. D., LL. D.**

(Father of the American Medical Association. By Isaac N. Danforth, A. M., M. D., Chicago.)

We take great pleasure in announcing the early issuance of a comprehensive "life" of the late N. S. Davis by that "prince of raconteurs" and contemporary teacher and practitioner, I. N. Danforth. The conjunction of such a subject of sterling interest and power with the virile and anecdotal pen of the biographer insures beyond any question of doubt a result of the keenest satisfaction.

That N. S. Davis presented by far the most vigorous personality in the general uplift of the medical profession during a long generation, and that his influence will remain stamped upon the daily activities, the conventions and the evolution of medical men in general, is very widely and freely admitted. The unwavering integrity of the man; his life long adherence to great principles; his powerful influence in building up real structures out of chaotic elements; his example as a man, first of all, and as an organizer, a teacher, a practitioner, a citizen, a philosopher, a friend, etc., etc.—all set forth in a style of fascinating simplicity and flow—afford material for a volume to delight the mind and quicken the energy of every Æsculapian.

There is something here that has not before dwelt in American medicine. There were influences during the fifty years just passed that will not be duplicated and that demanded a leader of peculiar talents and inflexible constancy. The times, no doubt, called forth the man; the man moulded a history that may be cherished as a heritage of dignity by the present and succeeding generations.

Aside, however, from the facts of formal history, and having an interest peculiarly isolated, are the many personalities and recollections of contemporaries, together with the characteristics that made him a central figure and his name a common one among physicians throughout the land. These have been especially well brought out, and the reader who thinks of meeting "only a lot of dry old chronicles" will find that his "guess" proved very far from the mark.

Published in a size and style uniform with the new (2nd) edition of Davis' History of Medicine. Cleveland Press, Ogden Avenue and Lincoln Street, Chicago.

THE JOURNAL OF THE
DIRECTORY.

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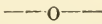
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List of Members in Good Standing in the Kansas Medical Society

Some corrections have been made in list of members in good standing, and for that reason they will be carried another month. Attention of secretaries of county societies is called to this list, and if there are any errors, kindly call attention of editor to the errors.

ALLEN COUNTY.

W. R. Heylman	Iola, Kan.
H. A. Brown	Iola, Kan.
G. W. Moore	Gas, Kan.
P. S. Mitchell	Iola, Kan.
C. W. Rennick	Gas, Kan.
G. W. Longenecker	Elsmore, Kan.
W. H. McDowell	Iola, Kan.
J. E. Jewell	Moran, Kan.
F. H. Martin	Iola, Kan.
J. S. Bass	Iola, Kan.
S. A. Coffman	Iola, Kan.
L. Tozer	Iola, Kan.
O. L. Garlinghouse	Iola, Kan.
J. H. Hindman	Humboldt, Kan.

J. W. Bolton	Iola, Kan.
O. C. Payne	Humboldt, Kan.
C. J. Halm	LaHarpe, Kan.
E. L. Hendricks	Iola, Kan.
G. E. Lambeth	Moran, Kan.

ANDERSON COUNTY.

J. E. Milligan	Garnett, Kan.
J. B. Jones	Garnett, Kan.
Martha E. Cunningham	Garnett, Kan.
C. L. Simmons	Westphalia, Kan.
A. H. Skillman	Mont Ida, Kan.
E. T. Metcalf	Colony, Kan.
T. A. Hood	Garnett, Kan.
D. O. Taylor	Greeley, Kan.

Thos. Kirkpatrick	Garnett, Kan.	Anna Perkins	Eldorado, Kan.
G. A. Blasdel	Garnett, Kan.	C. E. Hunt	Eldorado, Kan.
W. M. Caton	Colony, Kan.	J. B. Carlile	Leon, Kan.
J. C. Smith	Greeley, Kan.	J. D. Hamilton	Douglas, Kan.
E. L. Heidrick	Welda, Kan.		
R. W. Hull	Kincaid, Kan.		
C. F. Milligan	Garnett, Kan.		
F. A. Settle	Harris, Kan.		
R. C. Splawn	Kincaid, Kan.		
Chas. E. Longacre ..	Westphalia, Kan.		

ATCHISON COUNTY.

C. H. Linley	Atchison, Kan.
A. B. Chase	Atchison, Kan.
W. T. Dingess	Atchison, Kan.
E. P. Pitts	Atchison, Kan.
E. T. Shelly	Atchison, Kan.
C. A. Lilly	Atchison, Kan.
P. S. Moore	Effingham, Kan.
C. J. Cale	Huron, Kan.
A. L. Charles	Lancaster, Kan.
H. Linley	Atchison, Kan.
D. W. Campbell	Atchison, Kan.
C. S. Ferguson	Atchison, Kan.
Lydia Stockwell	Atchison, Kan.
J. P. Blunk	Atchison, Kan.
J. T. Preston	Effingham, Kan.
G. W. Allaman	Atchison, Kan.

BROWN COUNTY.

J. J. Comer	Willis, Kan.
F. Dunlap	Horton, Kan.
J. M. Eisenbise	Fairview, Kan.
R. L. Funk	Powhattan, Kan.
S. T. Gillespie	Reserve, Kan.
S. J. Herrick	Everett, Kan.
J. D. Horn	Horton, Kan.
G. C. McKnight	Hiawatha, Kan.
A. McGauley	Robinson, Kan.
W. B. McKinstrey	Hamlin, Kan.
E. J. Leigh	Hiawatha, Kan.
L. Reynolds	Horton, Kan.
C. C. Stivers, Jr.	Horton, Kan.
C. C. Stivers, Sr.	Horton, Kan.
R. Steward	Powhattan, Kan.
L. W. Shannon	Hiawatha, Kan.
V. C. VanVoorhis	Robinson, Kan.
J. O. Ward	Horton, Kan.
H. J. Deaver	Fairview, Kan.
F. H. Erwin	Morril, Kan.
G. S. Graham	Fairview, Kan.
A. C. Davis	Hamlin, Kan.
W. W. Nye	Hiawatha, Kan.
W. G. Atwood	Fairview, Kan.

BUTLER COUNTY.

J. R. McCluggage	Douglas, Kan.
D. C. Stahlman	Potwin, Kan.
F. E. Dillenbeck	Eldorado, Kan.
P. B. Smith	Augusta, Kan.
J. S. Kline	Eldorado, Kan.
C. H. McMillin	Leon, Kan.
W. O. Bennett	Eldorado, Kan.

BARTON COUNTY.

S. S. Meyer	Hoisington, Kan.
Ed Atkins	Olmitz, Kan.
O. P. McPherson	Gt. Bend, Kan.
H. W. Jury	Clafflin, Kan.
E. E. Morrison	Gt. Bend, Kan.
G. O. Speirs	Ellinwood, Kan.
A. H. Connett	Gt. Bend, Kan.
R. H. Meade	Gt. Bend, Kan.
P. L. Howe	Olmitz, Kan.
J. H. Morgan	Dighton, Kan.
A. R. Haas	Ellinwood, Kan.
M. L. Daniels	Fawnee Rock, Kan.
A. R. Lash	Ellinwood, Kan.
C. C. Koons	Larned, Kan.
E. C. Button	Gt. Bend, Kan.

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It. Aikman	Ft. Scott, Kan.
J. B. Carver	Ft. Scott, Kan.
W. L. Griffin	Ft. Scott, Kan.
W. H. Hayes	Ft. Scott, Kan.
M. F. Jarrett	Ft. Scott, Kan.
R. A. McLemore	Ft. Scott, Kan.
E. B. Payne	Ft. Scott, Kan.
J. S. Cummings	Bronson, Kan.
L. W. Sheeler	Devon, Kan.
J. L. Daugherty	Hiattville, Kan.
E. E. Anderson	Garland, Kan.
J. T. Holeman	Garland, Kan.
A. J. Wood	Fulton, Kan.
R. R. Hunter	Fulton, Kan.
J. R. Nusman	Ft. Scott, Kan.
W. L. Hopper	Ft. Scott, Kan.
S. C. Hall	Ft. Scott, Kan.
C. A. Van Velzer	Ft. Scott, Kan.
W. S. McDonald	Ft. Scott, Kan.
A. L. Harrar	Ft. Scott, Kan.
W. S. Gooch	Mapleton, Kan.
W. S. Miller	Uniontown, Kan.
A. J. Roberts	Ft. Scott, Kan.

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C. S. Huffman	Columbus, Kan.
J. P. Scoles	Galena, Kan.
H. B. Savage	Galena, Kan.
F. D. Northup	Galena, Kan.
R. M. Markham	Scammon, Kan.
J. H. Boss	Weir, Kan.
H. H. Brookhart	Scammon, Kan.
A. T. Revell	Scammon, Kan.
G. B. McClellan	Weir, Kan.
W. N. Johnson	Columbus, Kan.
J. D. Graham	Artesia, N. M.
J. H. Greene	Galena, Kan.
A. A. Shelly	Galena, Kan.
H. A. Brown	Galena, Kan.
R. S. Mahan	East Mineral, Kan.

A. R. Holmes ——— Kan.
 R. C. Wear Baxter Springs, Kan.
 R. C. Lowdermilk Galena, Kan.
 F. L. Ball Hallowell, Kan.
 W. R. Scott Columbus, Kan.
 J. H. Boswell .. Baxter Springs, Kan.
 G. W. Walker Chetopa, Kan.
 C. H. Jones Galena, Kan.
 J. H. Buckles Mineral, Kan.
 P. J. Hendrickson Columbus, Kan.
 H. P. Mahan Parsons, Kan.
 G. P. Bell Mineral, Kan.
 L. W. Baxter Columbus, Kan.
 H. A. Leaming Crestline, Kan.
 Chas. T. Reid Carona, Kan.
 O. L. Young Sherwin, Kan.

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 C. F. Leslie Clyde, Kan.
 W. B. Newton Glasco, Kan.
 J. H. Brierly Glasco, Kan.
 G. N. Hartwell Jamestown, Kan.
 F. A. McDonald Aurora, Kan.
 R. J. McLaughlin Hollis, Kan.
 W. R. Priest Concordia, Kan.
 S. C. Pigman Concordia, Kan.
 W. F. Sawhill Concordia, Kan.
 A. J. Weaver Concordia, Kan.
 G. W. Coffey Concordia, Kan.
 A. R. Marcotte Concordia, Kan.
 Chas. Caton Concordia, Kan.
 E. Tourigney Aurora, Kan.
 F. E. Way Concordia, Kan.

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M. W. Harner Clay Center, Kan.
 R. C. Harner Green, Kan.
 B. F. Morgan Clay Center, Kan.
 R. J. Morton Green, Kan.
 D. J. Moore Idana, Kan.
 X. Olsen Clay Center, Kan.
 M. C. Porter Clay Center, Kan.
 S. E. Reynolds Clay Center, Kan.
 J. P. Stewart Clay Center, Kan.
 C. C. Stillman Morganville, Kan.
 R. A. Stewart Russell, Kan.
 T. E. Schwarz .. Clay Center, Kan.
 G. A. Tull Clay Center, Kan.
 D. P. Cook Clay Center, Kan.
 J. A. Phillipsen Clifton, Kan.
 S. M. Edgerton .. Leonardville, Kan.
 S. W. Schenberger Industry, Kan.
 C. I. Welsh Clifton, Kan.
 J. E. Hewett Wakefield, Kan.
 W. M. Droll Leonardville, Kan.

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H. M. Bacon Nelson, Kan.
 H. H. Bogle Pittsburg, Kan.
 H. B. Caffey Pittsburg, Kan.
 G. E. Cole Girard, Kan.
 H. K. Cowan Midway, Kan.

D. A. Iliff Cherokee, Kan.
 M. K. Scott Frontenac, Kan.
 J. G. Sandidge Mulberry, Kan.
 A. C. Graves Pittsburg, Kan.
 C. Passuedetti Pittsburg, Kan.
 Wm. Williams Pittsburg, Kan.
 G. W. Williams Pittsburg, Kan.
 J. J. Cavanaugh Walnut, Kan.
 C. R. Tinder Englevale, Kan.
 C. M. Bertholf Cherokee, Kan.
 A. A. Dickinson Pittsburg, Kan.
 L. P. Adamson Girard, Kan.
 Frances A. Harper .. Pittsburg, Kan.
 A. O. Blair Pittsburg, Kan.
 Arthur Moberg Pittsburg, Kan.
 R. B. Gibb Pittsburg, Kan.
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 L. A. Newton Chicopee, Kan.
 Chas. Chapin Frontenac, Kan.
 H. L. Steele Pittsburg, Kan.
 J. F. McNaught Girard, Kan.
 C. A. Dudley Pittsburg, Kan.
 F. L. Keeler Farlington, Kan.

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C. M. Holcomb Winfield, Kan.
 J. A. Jacobus Winfield, Kan.
 F. B. Emory Winfield, Kan.
 T. E. Hinshaw Winfield, Kan.
 W. T. McKay .. Arkansas City, Kan.
 Geo. S. Morris, Arkansas City, Kan.
 G. P. Wagoner Dexter, Kan.
 S. J. Guy Winfield, Kan.
 C. E. Pugh Winfield, Kan.
 H. L. Snyder Winfield, Kan.
 E. F. Day Arkansas City, Kan.
 B. C. Geeslin .. Arkansas City, Kan.
 A. W. Dortch .. Arkansas City, Kan.
 W. H. Monser Burden, Kan.
 C. T. Ralls Winfield, Kan.
 H. C. Burson Maple City, Kan.
 Chas. Dunning .. Arkansas City, Kan.
 J. H. Gwinn Arkansas City, Kan.
 G. W. Hawkins Dexter, Kan.
 R. R. Teller Arkansas City, Kan.
 B. F. Hawk Arkansas City, Kan.
 W. H. Carter Atlanta, Kan.
 I. W. Clark Winfield, Kan.
 W. J. Hall Winfield, Kan.
 Ida C. Hall Winfield, Kan.
 H. C. Binson Maple City, Kan.
 Lloyd Clary Winfield, Kan.
 F. M. Wilmer Winfield, Kan.
 O. B. Wyant Winfield, Kan.

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 B. E. Garrison Sedan, Kan.
 W. T. Courtwright Sedan, Kan.
 Milton T. Evans Sedan, Kan.
 I. N. Whitney Cedarvale, Kan.
 B. F. Finn Cedarvale, Kan.

W. L. Jack Chautauqua, Kan.
 Fred Calhoun Peru, Kan.
 W. L. McNaughton Elgin, Kan.
 R. S. Lynn Chautauqua, Kan.
 H. S. Lamden Peru, Kan.
 Wm. Floyd Peru, Kan.
 J. D. Stevens Peru, Kan.
 J. M. Ennis Cedarvale, Kan.
 D. G. Hahn Wauneta, Kan.
 L. D. Fout Cedarvale, Kan.

COFFEY COUNTY.

J. C. Fear Waverly, Kan.
 C. L. Davidson Waverly, Kan.
 A. K. Berry Burlington, Kan.
 W. H. Mathis Waverly, Kan.
 V. McMullin Burlington, Kan.
 D. B. Rowe LeRoy, Kan.
 H. T. Salisbury Burlington, Kan.
 G. R. Noris Burlington, Kan.
 M. L. Stockton Gridly, Kan.
 B. E. Egan Waverly, Kan.

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 E. E. Hazlett Abilene, Kan.
 Simeon Steelsmith Abilene, Kan.
 P. B. Witmer Abilene, Kan.
 J. R. Conklin Abilene, Kan.
 Royal McShea Abilene, Kan.
 J. J. O'Brien Chapman, Kan.
 J. D. Riddell Enterprise, Kan.
 Leslie Leverick Solomon, Kan.
 F. M. Gaines Solomon, Kan.
 J. C. Klepinger Herrington, Kan.
 J. N. Ketchersid Hope, Kan.
 S. W. Schenberger Industry, Kan.
 Geo. E. White Holland, Kan.
 W. A. Klingburg Elmo, Kan.
 S. N. Chaffee Talmage, Kan.
 F. W. Montgomery Navarre, Kan.
 A. S. Gish Abilene, Kan.
 Schuyler Nichols Herrington, Kan.
 W. M. Van Scoyoc, Manchester, Kan.
 G. Greenlee Solomon, Kan.
 E. F. Hoover Enterprise, Kan.
 A. R. Marcotte Enterprise, Kan.
 C. H. Maust Donegal, Kan.
 C. B. Buck Abilene, Kan.

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A. Herring Highland, Kan.
 J. H. McGauhey White Cloud, Kan.
 W. M. Boone Highland, Kan.
 Herbert H. Smith Highland, Kan.
 J. W. Hobson White Cloud, Kan.
 R. R. Clutz Bendena, Kan.
 F. E. Horner Severance, Kan.
 S. H. Blakely Severance, Kan.
 H. G. Herring Highland, Kan.
 A. E. Cardonier Troy, Kan.

DOUGLAS COUNTY.

E. J. Blair Lawrence, Kan.
 H. L. Charles Lecompton, Kan.
 J. P. Gergen Big Springs, Kan.
 H. T. Jones Lawrence, Kan.
 G. W. Jones Lawrence, Kan.
 G. A. Hammon Lawrence, Kan.
 F. D. Morse Lawrence, Kan.
 E. R. Keith Lawrence, Kan.
 E. Smith Lawrence, Kan.
 F. D. G. Harvey Lawrence, Kan.
 James Naismith Lawrence, Kan.
 E. D. F. Phillips Lawrence, Kan.
 B. H. Leslie Lawrence, Kan.
 C. J. Simmons Lawrence, Kan.
 A. W. Clark Lawrence, Kan.
 S. C. Emley Lawrence, Kan.
 Carl Phillips Lawrence, Kan.
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 A. Gifford Lawrence, Kan.
 M. T. Sudler Lawrence, Kan.
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 J. L. Hays Howard, Kan.
 J. F. Costello Howard, Kan.
 C. W. Maddox Longston, Kan.
 B. R. O'Connor Grenola, Kan.
 M. G. Fox Elk Falls, Kan.
 G. H. Grimmell Howard, Kan.
 F. L. Depew Howard, Kan.

GEARY COUNTY.

C. E. Steadman Junction City, Kan.
 P. J. Moyer Junction City, Kan.
 P. W. O'Donnell Junction City, Kan.
 L. R. King Junction City, Kan.
 W. S. Yates Junction City, Kan.
 T. E. McCord Milford, Kan.
 L. S. Steadman Junction City, Kan.

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L. S. Trusler Fall River, Kan.
 J. Dillon Eureka, Kan.
 N. S. McDonald Severy, Kan.
 S. F. McDonald Severy, Kan.
 D. F. Butcher Severy, Kan.
 B. L. Hale Neal, Kan.
 W. T. Grove Eureka, Kan.
 H. W. Manning Eureka, Kan.
 E. J. Norman Eureka, Kan.
 W. S. Moonlight Eureka, Kan.
 James M. Moore Madison, Kan.
 S. L. Axford Virgil, Kan.
 J. S. Black Madison, Kan.
 J. R. Pusey Quincy, Kan.
 W. H. Yandell Piedmont, Kan.
 A. B. Lewis Hamilton, Kan.
 J. M. Winegar Hamilton, Kan.
 C. L. Katz Madison, Kan.

T. H. Hale Fall River, Kan.
 D. R. Campbell Severy, Kan.
 W. F. Hoover Climax, Kan.

HARVEY COUNTY.

J. T. Axtell Newton, Kan.
 Max Miller Newton, Kan.
 G. D. Bennett Newton, Kan.
 A. E. Smolt Newton, Kan.
 I. L. Abbey Newton, Kan.
 O. W. Roff Newton, Kan.
 J. W. Graybill Newton, Kan.
 R. C. McClymonds Walton, Kan.
 I. T. Smith Newton, Kan.
 S. S. Haury Newton, Kan.
 H. L. Wood Whitewater, Kan.
 A. E. Hertzler Halstead, Kan.
 J. L. Grove Newton, Kan.
 R. S. Haury Halstead, Kan.
 E. E. Wattke Halstead, Kan.

HARPER COUNTY.

J. C. A. Bowles Bluff City, Kan.
 B. F. Hawk Bluff City, Kan.
 C. W. Windbigler Harper, Kan.
 G. M. Wooden Anthony, Kan.
 A. D. Updegraff Anthony, Kan.
 A. E. Walker Anthony, Kan.
 B. H. Jordan Waldron, Kan.
 J. A. Hazel Freeport, Kan.
 A. J. McAdams Harper, Kan.

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A. B. Peters Mankato, Kan.
 Dorothy D. Allen Mankato, Kan.
 L. A. Carter Randall, Kan.
 O. W. Hughes Jewell, Kan.
 H. M. Hitner Eshon, Kan.
 C. R. Spain Jewell, Kan.
 J. E. Blades Randall, Kan.
 J. W. Johnson Formosa, Kan.
 J. E. Hawley Burr Oak, Kan.
 Chas. Hershner, North Branch, Kan.
 M. B. Sherrard Mankato, Kan.

JACKSON COUNTY.

V. V. Adamson Holton, Kan.
 W. P. Brockett Mayetta, Kan.
 H. F. Carver Circleville, Kan.
 C. W. Culp Hoyt, Kan.
 F. T. Myers Netawaka, Kan.
 Geo. E. Lock Holton, Kan.
 J. W. Pettijohn Hoyt, Kan.
 E. W. Reed Holton, Kan.
 Chas. W. Reynolds Holton, Kan.
 J. E. Love Whiting, Kan.
 J. W. Murray Hoyt, Kan.
 R. Robson Mayetta, Kan.
 J. W. Darlington Denison, Kan.
 J. R. Mainz Whiting, Kan.
 F. W. Noble Circleville, Kan.
 J. C. Shaw Holton, Kan.

JEFFERSON COUNTY.

W. A. Aitkins Valley Falls, Kan.
 J. B. Armstead Winchester, Kan.
 L. Atwood Meriden, Kan.
 W. L. Barst McLouth, Kan.
 G. W. England Valley Falls, Kan.
 S. Johnson Oskaloosa, Kan.
 A. D. Lowry Ozawkie, Kan.
 A. G. Smith Oskaloosa, Kan.
 S. E. Smith Grantville, Kan.
 D. D. Wilson Nortonville, Kan.
 J. T. Fulton Donovan, Kan.
 A. C. Zimmerman Perry, Kan.
 Chas. F. Martin Winchester, Kan.
 E. C. Rankin McLouth, Kan.
 W. D. Groff Nortonville, Kan.
 F. Burns Perry, Kan.
 J. L. Work Meriden, Kan.
 Ira Puderbaugh Ozawkie, Kan.
 M. S. McCreight Oskaloosa, Kan.
 W. S. Hunter Valley Falls, Kan.
 C. C. Kerr Perry, Kan.
 L. V. Sams Rock Creek, Kan.

JOHNSON COUNTY.

C. R. Fear Gardner, Kan.
 T. S. Greer Edgerton, Kan.
 F. F. Green Olathe, Kan.
 W. C. Harkey Gardner, Kan.
 H. E. Hastings Olathe, Kan.
 Thos. Hamel Olathe, Kan.
 George Jewett Edgerton, Kan.
 Robert M. Moore Olathe, Kan.
 F. B. Stout Olathe, Kan.
 Jessie Thomas Olathe, Kan.
 H. E. Williamson Olathe, Kan.
 Carl Thomas Spring Hill, Kan.
 C. Warner Jones Lenexa, Kan.
 J. R. Sloan Stanley, Kan.
 Jessie T. Orr Olathe, Kan.
 O. C. Thomas Spring Hill, Kan.
 Fred P. Mann Valley Falls, Kan.

KINGMAN COUNTY.

E. W. Hinton Kingman, Kan.
 H. L. Mills Pensaloosa, Kan.
 J. W. Cheney Kingman, Kan.
 A. C. Johnson New Murdock, Kan.
 Ira D. Nelson Spivey, Kan.
 H. E. Haskins Kingman, Kan.
 M. H. Haskins Kingman, Kan.
 S. W. Nossman Cunningham, Kan.
 J. S. Caldwell Kingman, Kan.
 C. W. Longenecker .. Kingman, Kan.
 O. A. Duncan Norwich, Kan.
 Chas. E. Phillips Zenda, Kan.
 Eugene Wallace Belmont, Kan.

LYON COUNTY.

G. A. Biddle Emporia, Kan.
 T. C. Biddle Topeka, Kan.
 J. C. Brickell Americus, Kan.

M. D. Brown Lebo, Kan.
 T. G. Burris Allen, Kan.
 L. B. Bushong Admire, Kan.
 C. J. Corbett Emporia, Kan.
 H. E. Davis Emporia, Kan.
 F. A. Eckdall Emporia, Kan.
 F. A. Foncannon Emporia, Kan.
 C. D. Hatcher Admire, Kan.
 Jacob Hindon Strong City, Kan.
 D. F. Longenecker Emporia, Kan.
 J. H. Page Emporia, Kan.
 J. M. Parrington Emporia, Kan.
 S. P. Reeser Hartford, Kan.
 T. E. Welsh Emporia, Kan.
 D. L. Morgan Emporia, Kan.
 J. C. Hughes Hartford, Kan.
 J. F. Hughes Hartford, Kan.
 C. F. Lusk Lebo, Kan.
 H. W. Edgerton Americus, Kan.
 G. M. Gafford Emporia, Kan.
 D. M. Gafford Emporia, Kan.
 J. H. Jaquith Council Grove, Kan.
 C. L. Stocks Bushong, Kan.
 T. O. Brown Reading, Kan.
 L. S. Harvey Dunlap, Kan.
 J. L. Roberts Dunlap, Kan.
 C. A. Neighbors Emporia, Kan.
 C. F. Hoover Saffordville, Kan.
 C. W. Lawrence Emporia, Kan.

LINN COUNTY.

L. R. Ashley Pleasanton, Kan.
 S. H. Brooks Mound City, Kan.
 H. L. Clark LaCygne, Kan.
 D. E. Green Pleasanton, Kan.
 Geo. W. Vail Parker, Kan.
 T. W. Warner Parker, Kan.
 C. P. Lee Pleasanton, Kan.
 J. G. Wortman Mound City, Kan.
 F. E. Casburn LaCygne, Kan.

LEAVENWORTH COUNTY.

M. L. Crozier Lansing, Kan.
 C. C. Goddard Leavenworth, Kan.
 S. McKee Leavenworth, Kan.
 R. L. Boling Leavenworth, Kan.
 H. J. Stacy Leavenworth, Kan.
 J. S. Wever Leavenworth, Kan.
 E. S. Wood Jarbalo, Kan.
 C. E. Brown Leavenworth, Kan.
 C. K. Vaughn Leavenworth, Kan.
 R. L. Igel Leavenworth, Kan.
 J. W. Risdon Leavenworth, Kan.
 C. M. Moates Leavenworth, Kan.
 A. J. Smith Leavenworth, Kan.
 J. D. Miller Leavenworth, Kan.
 S. B. Langworthy, Leavenworth, Kan.
 C. J. McGee Leavenworth, Kan.
 J. L. Everhardy Leavenworth, Kan.
 J. N. Phillips Boulder, Col.
 W. B. Coe Tonganoxie, Kan.
 J. L. Pryer Leavenworth, Kan.
 C. Lloyd Leavenworth, Kan.

J. G. Jones Tonganoxie, Kan.

LABETTE COUNTY.

T. B. Allison Parsons, Kan.
 G. S. Liggett Oswego, Kan.
 E. E. Liggett Oswego, Kan.
 L. B. Kackley Parsons, Kan.
 R. M. Bennett Mound Valley, Kan.
 H. L. Markham Parsons, Kan.
 C. F. Brady Parsons, Kan.
 M. L. Perry Parsons, Kan.
 O. S. Hubbard Parsons, Kan.
 A. L. Skoog Parsons, Kan.
 J. B. Anderson Chetopa, Kan.
 R. L. VonTrebra Chetopa, Kan.
 E. W. Boardman Parsons, Kan.
 G. W. Maser Parsons, Kan.
 J. C. Creel Parsons, Kan.
 Albert Smith Parsons, Kan.
 G. W. Gabriel Parsons, Kan.
 J. W. Henderson Labette, Kan.
 James Heacock Parsons, Kan.
 P. W. Barbe Oswego, Kan.
 J. T. Tinder Parsons, Kan.
 C. N. Petty Altamont, Kan.
 A. D. Smith Parsons, Kan.
 A. M. Painter Parsons, Kan.
 G. H. Wellbrook Parsons, Kan.
 M. F. Crawford Parsons, Kan.
 O. H. Ball Dennis, Kan.

LINCOLN COUNTY.

O. W. Shalksohm, Sylvan Grove, Kan.
 Otto F. Dierker .. Sylvan Grove, Kan.
 James Loughridge .. Lincoln, Kan.
 H. L. Hinckley Barnard, Kan.
 G. W. Anderson Beverly, Kan.
 H. M. Butler Orgallah, Kan.
 A. W. Townsden Barnard, Kan.
 W. A. Hulén Lincoln, Kan.
 A. Hultner Lincoln, Kan.
 H. M. Hall Lincoln, Kan.

MITCHELL COUNTY.

F. M. Daily Beloit, Kan.
 F. B. Home Beloit, Kan.
 E. N. Daniels Beloit, Kan.
 D. S. O'Brien Beloit, Kan.
 E. E. Brewer Beloit, Kan.
 M. J. Lobdell Beloit, Kan.
 A. J. Seager Beloit, Kan.
 M. R. Spessard Glen Elder, Kan.
 M. R. Barst Beloit, Kan.
 N. J. Saunders Cawker City, Kan.
 E. G. Mason Cawker City, Kan.
 H. L. Ratcliff Cawker City, Kan.
 S. T. Bledis Scottville, Kan.
 J. F. Ullman Simpson, Kan.
 J. E. Graff Scottville, Kan.
 W. B. Cook Beloit, Kan.

MARION COUNTY.

L. A. Buck Peabody, Kan.

O. J. Furst Peabody, Kan.
 L. T. Morrell Peabody, Kan.
 James Welsh Tampa, Kan.
 S. M. Palmer Florence, Kan.
 L. S. Wager Florence, Kan.
 R. C. Smith Marion, Kan.
 J. Werthner Lincolnville, Kan.
 G. P. Marner Lincolnville, Kan.
 Grant Myers Lincolnville, Kan.
 S. E. McIntosh Burns, Kan.
 J. H. Seylor Ramona, Kan.
 H. M. Mayer Peabody, Kan.
 E. H. Johnson Peabody, Kan.
 W. W. Johnson Elbing, Kan.

MONTGOMERY COUNTY.

P. H. Dalby Havana, Kan.
 H. M. Casebeer .. Independence, Kan.
 W. E. Youngs Cherryvale, Kan.
 J. A. Pinkston .. Independence, Kan.
 B. F. Masterman, Independence, Kan.
 Ira B. Chadwick Tyro, Kan.
 D. W. Howell Havana, Kan.
 M. A. Pinley Cherryvale, Kan.
 O. W. Demott Independence, Kan.
 E. C. Wickersham, Independence, Kan.
 W. C. Chaney Independence, Kan.
 J. H. Johnson Coffeyville, Kan.
 C. C. Surber Independence, Kan.
 W. C. Hall Coffeyville, Kan.
 Mamie J. Tanquary, Independence, Kan.
 E. D. Tanquary Coffeyville, Kan.
 Mary L. Martin .. Coffeyville, Kan.
 J. R. Scott Independence, Kan.
 F. W. Shelton Independence, Kan.
 T. A. Stevens Caney, Kan.
 G. W. Seacat Cherryvale, Kan.
 J. F. Gard Cherryvale, Kan.
 A. A. Krugg Coffeyville, Kan.
 C. H. Fortner Coffeyville, Kan.
 G. J. Biglow Caney, Kan.
 J. A. Rader Caney, Kan.
 J. L. Barker Jefferson, Kan.
 W. F. Blewett Caney, Kan.
 Ida M. Scott Independence, Kan.
 C. I. Caldwell Caney, Kan.
 W. E. Curd Copen, I. T.
 W. P. Booker Caney, Kan.
 J. S. Scott Independence, Kan.

MARSHALL COUNTY.

M. A. Brawley* Frankfort, Kan.
 W. E. Ham Beattie, Kan.
 M. S. Thacher Blue Rapids, Kan.
 J. L. Hausman Marysville, Kan.
 W. R. Breeding Marysville, Kan.
 R. S. Fillmore Blue Rapids, Kan.
 D. W. Humfreville Waterville, Kan.
 H. Humfreville Waterville, Kan.
 G. S. Thacher Waterville, Kan.
 J. W. Chambers Waterville, Kan.
 B. P. Hatch Beattie, Kan.
 J. L. Eddington Marysville, Kan.

E. L. Willson, Sr., .. Marysville, Kan.
 E. L. Willson, Jr., .. Marysville, Kan.

MIAMI COUNTY.

J. D. Van Nuys Osawatomie, Kan.
 S. L. Brooking Paola, Kan.
 W. E. Craig Osawatomie, Kan.
 N. C. Spurs Osawatomie, Kan.
 L. L. Uhls Osawatomie, Kan.
 J. H. Haldeman Paola, Kan.
 D. H. Johnson Paola, Kan.
 J. D. Walthall Paola, Kan.
 J. W. Kelly Louisburg, Kan.
 F. H. Redmond Osawatomie, Kan.
 L. R. Sellers Osawatomie, Kan.
 NORTON & DECATUR COUNTIES.
 H. O. Hardesty Jennings, Kan.
 Chas. W. Cole Norton, Kan.
 J. J. Dallal Norcatur, Kan.
 C. C. Funk Jennings, Kan.
 C. S. Kenney Norcatur, Kan.
 W. Munroe Jones Norcatur, Kan.
 Robert H. Smith Oberlin, Kan.
 J. E. Hodgman Long Island, Kan.
 W. C. Lathrop Norton, Kan.
 E. L. Davis Dresden, Kan.
 J. M. Gaume Jennings, Kan.
 S. C. Standard Clayton, Kan.
 C. G. Brethouwer Norton, Kan.

M'PHERSON COUNTY.

Geo. R. Dean McPherson, Kan.
 J. C. Hall McPherson, Kan.
 A. Engberg McPherson, Kan.
 J. B. Alexander .. McPherson, Kan.
 C. D. Weaver Galva, Kan.
 E. O. Smith Marquette, Kan.
 V. I. Vestling Marquette, Kan.
 J. C. Ulery Windom, Kan.

NEOSHO COUNTY.

W. K. Mathis Chanute, Kan.
 Geo. H. Brown Chanute, Kan.
 L. D. Johnson Chanute, Kan.
 J. B. Edwards Chanute, Kan.
 M. A. Duncan Chanute, Kan.
 R. A. Light Chanute, Kan.
 U. G. Hoshaw Chanute, Kan.
 F. R. Hickey Chanute, Kan.
 O. M. Edwards Chanute, Kan.
 J. C. Lardner Chanute, Kan.
 P. F. Wellman Chanute, Kan.
 J. W. Barker Chanute, Kan.
 W. E. Barker Chanute, Kan.
 A. M. Davis Chanute, Kan.
 H. E. Rakestraw Chanute, Kan.
 E. A. Davis Chanute, Kan.
 J. Allen Palmer Erie, Kan.
 J. J. McNamara St. Paul, Kan.
 M. E. Lake Erie, Kan.
 G. W. Morgan Kimball, Kan.
 C. L. Randall Morehead, Kan.

W. C. McConnell .. Morehead, Kan.
 R. C. Henderson Chanute, Kan.
 J. H. Light Chanute, Kan.
 G. C. Thompson Galesburg, Kan.
 T. R. Edwards Chanute, Kan.
 D. B. Moore Osage City, Kan.

NEMAHA COUNTY.

J. H. Brown Centralia, Kan.
 D. H. Fitzgerald Kelly, Kan.
 J. W. Graham Wetmore, Kan.
 N. Hayes Seneca, Kan.
 U. G. Iles Seneca, Kan.
 Joseph Haig Wetmore, Kan.
 J. C. Mason Goff, Kan.
 G. W. Shelton Oneida, Kan.
 H. G. Snyder Seneca, Kan.
 Benj. Skinner Wetmore, Kan.
 Preston Thompson Corning, Kan.
 C. R. Townsend Centralia, Kan.
 A. J. Best Centralia, Kan.
 W. L. Carlyle Sabetha, Kan.
 C. M. Fisher Sabetha, Kan.
 W. A. Haynes Sabetha, Kan.
 I. H. Magill Corning, Kan.
 S. Murdock Sabetha, Kan.
 Harry Reading Sabetha, Kan.
 Geo. Hall Baileyville, Kan.
 R. E. Wright Bern, Kan.
 W. L. Shelton Woodlawn, Kan.
 G. S. Graham Wetmore, Kan.
 S. Murdock Sr. Sabetha, Kan.

OSBORNE COUNTY.

J. B. Armstrong Portis, Kan.
 T. B. Felix Osborne, Kan.
 E. O. Henshall Osborne, Kan.
 H. R. St. John Osborne, Kan.
 T. O. Felix Downs, Kan.
 B. F. Chilloctt Osborne, Kan.
 A. C. Dillon Osborne, Kan.
 E. E. Isenberg Natoma, Kan.
 A. A. Thompson Osborne, Kan.
 C. L. Ebnother Downs, Kan.
 G. W. Franklin Downs, Kan.
 K. B. Mays Covert, Kan.
 S. J. Schoop Osborne, Kan.

OTTOWA COUNTY.

C. B. Alpin Delphos, Kan.
 J. F. Brewer Minneapolis, Kan.
 A. L. Cludas Minneapolis, Kan.
 Geo. E. Eye Delphos, Kan.
 Wm. H. Lee Ada, Kan.
 Jno. Miller Minneapolis, Kan.
 C. D. Vermillion Tescott, Kan.
 J. W. Simmons Culver, Kan.
 F. E. Roberts Bennington, Kan.
 Fred Harvey Minneapolis, Kan.

OSAGE COUNTY.

J. M. Heller Osage City, Kan.
 Jas. Ball Melvern, Kan.

C. C. Seabrook Burlingame, Kan.
 C. F. Marcotte Osage City, Kan.
 F. E. Schenck Burlingame, Kan.
 D. B. Moore Osage City, Kan.
 A. F. Harrison Scranton, Kan.
 E. F. Milligan Burlingame, Kan.
 S. J. Hampshire Overbrook, Kan.
 Dr. McNally Michigan Valley, Kan.
 J. N. Beesley Topeka, Kan.
 D. W. Melton Burlingame, Kan.
 C. W. Main Overbrook, Kan.

PRATT COUNTY.

C. F. Bucklin Sawyer, Kan.
 M. M. Lottridge Pratt, Kan.
 J. A. H. Webb Preston, Kan.
 Frank Peak Pratt, Kan.
 E. A. Gaston Pratt, Kan.
 Athol Cochran Iuka, Kan.
 J. J. Douthart Pratt, Kan.
 H. M. Walker Pratt, Kan.
 L. R. Bobzin Cullison, Kan.
 P. K. Gustin Pratt, Kan.
 C. D. Rogers Coats, Kan.

PHILLIPS COUNTY.

R. M. Tinney Kirwin, Kan.
 D. D. Haggard Phillipsburg, Kan.
 E. A. Nelson Phillipsburg, Kan.
 C. E. Nelson Phillipsburg, Kan.
 G. A. Van Diest .. Prairie View, Kan.
 W. G. LeRew Marvin, Kan.

POTTAWATOMIE COUNTY.

W. M. Reitzel Wamego, Kan.
 C. W. Rairdon Lewis, Kan.
 E. L. Simonton Wamego, Kan.
 Benj. Brunner .. Westmoreland, Kan.
 W. P. Wilson .. Westmoreland, Kan.
 R. F. Richardson Onaga, Kan.
 J. W. Wilhoit St. George, Kan.
 A. Cutright Louisville, Kan.
 P. T. Conlan St. Marys, Kan.
 L. A. Summers Wheaton, Kan.
 C. H. Kcentz Onaga, Kan.
 S. R. Toothaker Wheaton, Kan.
 J. E. McManus Havensville, Kan.
 O. R. Searl Belvue, Kan.
 B. K. Kilborne Emmett, Kan.
 J. M. Jennings Wamego, Kan.
 W. G. McDougall Wamego, Kan.
 J. W. Lauch Olsburg, Kan.

ROOKS COUNTY.

James Parker Woodson, Kan.
 E. E. Colby Woodson, Kan.
 N. L. Book Stockton, Kan.
 W. B. Callender Stockton, Kan.
 D. L. Sackrider Webster, Kan.
 D. F. Stough Stockton, Kan.
 Chas. E. Barber Palco, Kan.
 F. K. Meade Plainville, Kan.

G. R. Rice Plainville, Kan.
 Harry C. Brown Webster, Kan.
 P. W. Beckman Plainville, Kan.

RAWLINS & CHEYENNE COUNTIES
 J. N. Melugin Atwood, Kan.
 L. G. Graves Atwood, Kan.

RENO COUNTY.

R. A. Stewart Hutchinson, Kan.
 J. E. Stewart Hutchinson, Kan.
 D. B. Southard Haven, Kan.
 S. M. Callady Hutchinson, Kan.
 H. J. Duvall Hutchinson, Kan.
 J. E. Foltz Hutchinson, Kan.
 G. R. Gage Hutchinson, Kan.
 W. H. Bauer Sylvia, Kan.
 W. F. Schoor Hutchinson, Kan.
 C. Klippe Hutchinson, Kan.
 S. H. Sidlinger Hutchinson, Kan.
 H. S. Justice Hutchinson, Kan.
 Virgil Beavers Hutchinson, Kan.
 J. W. Maguire Hutchinson, Kan.
 C. A. Mann Hutchinson, Kan.
 E. V. Adams Plevna, Kan.
 C. S. Evans Partridge, Kan.
 T. O. Blair Turon, Kan.
 H. H. Heylman .. Hutchinson, Kan.
 E. H. Kasey Hutchinson, Kan.
 G. E. Webb Hutchinson, Kan.
 M. C. Roberts Hutchinson, Kan.

RILEY COUNTY.

C. F. Little Manhattan, Kan.
 J. D. Colt Manhattan, Kan.
 L. J. Lyman Manhattan, Kan.
 E. J. Moffitt Manhattan, Kan.
 W. D. Silkman Manhattan, Kan.
 T. R. Cave Manhattan, Kan.
 C. A. Roberts Randolph, Kan.
 G. H. Litsinger Riley, Kan.
 A. G. Henderson .. Leonardville, Kan.
 J. C. Montgomery .. Manhattan, Kan.
 W. H. Clarkson Manhattan, Kan.
 F. L. Murdock Manhattan, Kan.

RICE COUNTY.

P. P. Trueheart Sterling, Kan.
 H. R. Ross Sterling, Kan.
 W. E. Currie Sterling, Kan.
 C. E. Fisher Lyons, Kan.
 L. E. Vermillion Lyons, Kan.
 J. S. McBride Lyons, Kan.
 E. C. Fisher Lyons, Kan.
 F. R. Smith Little River, Kan.
 J. H. Powers Little River, Kan.
 F. W. Koons Chase, Kan.
 F. E. Wallace Frederick, Kan.
 Marion Trueheart Sterling, Kan.
 C. I. Forney Lyons, Kan.
 L. O. Forney Saxman, Kan.
 G. E. Bush Geneseo, Kan.
 A. H. Bressler Raymond, Kan.
 H. T. McLaughlin .. Sterling, Kan.
 Dr. Anderson Saxman, Kan.
 D. J. Muir Alden, Kan.

REPUBLIC COUNTY.

C. M. Arbuthnot Belleville, Kan.
 J. S. Billingsly Belleville, Kan.
 J. C. Decker ellville, Kan.
 J. W. Eckblad Scandia, Kan.
 D. E. Foristall Republic, Kan.
 T. C. Long Mundon, Kan.
 W. G. Hanning Belleville, Kan.
 C. V. Haggman Scandia, Kan.
 J. D. Johnson Republic, Kan.
 Wm. Kamp Belleville, Kan.
 W. I. McFarland Belleville, Kan.
 J. C. Sharrard Norway, Kan.
 F. J. Petr Cuba, Kan.
 J. B. Henry Scandia, Kan.
 S. J. Snider Courtland, Kan.
 Jes. A. Kahout Cuba, Kan.
 J. H. Houck Argenda, Kan.

SEDGWICK COUNTY.

C. E. McAdams Wichita, Kan.
 J. M. Latta Wichita, Kan.
 J. C. Brown Wichita, Kan.
 D. W. Basham Wichita, Kan.
 D. I. Maggard Wichita, Kan.
 G. C. Purdue Wichita, Kan.
 F. J. Walker Wichita, Kan.
 E. M. Palmer Wichita, Kan.
 J. F. Gsell Wichita, Kan.
 J. G. Dorsey Wichita, Kan.
 E. E. Hamilton Wichita, Kan.
 J. W. Cave Wichita, Kan.
 H. S. Hickok Wichita, Kan.
 J. W. Kirkwood Wichita, Kan.
 C. E. Bowers Wichita, Kan.
 I. B. Lyons Wichita, Kan.
 C. E. Scott Wichita, Kan.
 G. K. Purvis Wichita, Kan.
 C. E. Caldwell Wichita, Kan.
 J. D. Clark Wichita, Kan.
 A. H. Fabrique Wichita, Kan.
 J. E. Oldham Wichita, Kan.
 W. T. Logsdon Wichita, Kan.
 Martin Hagan Wichita, Kan.
 Jacob Z. Hoffman Wichita, Kan.
 E. S. Hymer Wichita, Kan.
 H. L. Scoles Mt. Hope, Kan.
 Wm. Sterrett Mt. Hope, Kan.
 S. M. Anderson Mt. Hope, Kan.
 D. G. Buley Valley Center, Kan.
 W. P. Greening .. Valley Center, Kan.
 L. P. Warren Clear Water, Kan.
 H. H. Miner Cheney, Kan.
 C. M. Fullenwider Wichita, Kan.
 Robert Baker Mt. Hope, Kan.
 S. A. Bass Wichita, Kan.
 F. S. Williams Wichita, Kan.
 E. H. Taggart Wichita, Kan.
 R. B. Blue Wichita, Kan.

P. Newman	Wichita, Kan.	R. A. McIlhenny, Conway Springs, Kan.	
F. E. Braucht	Wichita, Kan.	F. M. Owens	Argonia, Kan.
J. D. Barrett	Wichita, Kan.	T. J. Hollingsworth, South Haven, Kan.	
J. L. Evans	Wichita, Kan.	J. J. Sippey	Belle Plains, Kan.
C. D. Forney	Wichita, Kan.	W. E. Bartlett	Belle Plains, Kan.
O. G. Hutchinson	Wichita, Kan.	H. B. Morton	Mayfield, Kan.
A. D. Jones	Wichita, Kan.	F. G. Emerson	Wellington, Kan.
H. Michener	Wichita, Kan.	S. W. Spitler	Wellington, Kan.
K. B. Ford	Wichita, Kan.	J. L. Halliday	Wellington, Kan.
F. A. Kelly	Wichita, Kan.	J. A. Roe	Wellington, Kan.
W. A. Phares	Wichita, Kan.	H. L. Cobean	Wellington, Kan.
J. A. Connor	Viola, Kan.	L. F. Harmon	Wellington, Kan.
W. H. Graves	Wichita, Kan.	T. H. Jamison	Wellington, Kan.

SALINE COUNTY.

N. D. Toby	Salina, Kan.
W. H. Winterbotham ..	Salina, Kan.
W. S. Harvey	Salina, Kan.
W. B. Dewees	Salina, Kan.
J. R. Crawford	Salina, Kan.
J. W. Neptune	Salina, Kan.
H. N. Moses	Salina, Kan.
J. H. Winterbotham ..	Salina, Kan.
A. G. Anderson	Salina, Kan.
O. R. Brittain	Salina, Kan.
E. R. Tuttle	Salina, Kan.
L. O. Nordstrom	Assaria, Kan.
A. J. May	New Cambria, Kan.
E. R. Cheney	Gypsum, Kan.
E. W. Hawthorn	Gypsum, Kan.
C. D. Armstrong	Salina, Kan.
M. J. Brown	Salina, Kan.
W. E. Fowler	Brookville, Kan.
E. J. Lutz	Salina, Kan.
J. E. Metcalf	Salina, Kan.
O. D. Walker	Salina, Kan.
J. W. Simmons	Lindsborg, Kan.

SOUTHWEST JOINT.

T. L. McCarty	Dodge City, Kan.
C. B. Leslie	Meade, Kan.
C. E. McCarty	Dodge City, Kan.
G. F. Johnson	Lakin, Kan.
R. T. Nichols	Liberal, Kan.
A. B. Scott	Jetmore, Kan.
J. C. Bredhoft	Ford, Kan.
Wm. Lee	Meade, Kan.
O. L. Helwig	Garden City, Kan.
W. H. Graves	Dodge City, Kan.
H. Whitworth	Dodge City, Kan.
Hubert Fannon ..	Dodge City, Kan.
D. W. Thompson ..	Dodge City, Kan.
T. S. Higginbotham ..	Liberal, Kan.
C. S. Smith	Liberal, Kan.
G. B. Ingles	Jetmore, Kan.
Arthur L. Knisely	Liberal, Kan.

SUMNER COUNTY.

S. T. Shelly	Mulvane, Kan.
H. A. Vincent	Perth, Kan.
Eugene Pile	Portland, Kan.
Melvin Collins	Oxford, Kan.

SMITH COUNTY.

B. W. Slagle	Smith Center, Kan.
D. W. Relihan ..	Smith Center, Kan.
J. A. McCammon ..	Reamsville, Kan.
J. B. Dykes	Lebanon, Kan.
H. A. Dykes	Lebanon, Kan.
S. B. Dykes	Esbon, Kan.
W. C. Bower	Lebanon, Kan.
F. M. Bilby	Kensington, Kan.
W. H. Bostwick	Cedarville, Kan.
H. O. Hardesty	Reamsville, Kan.
E. W. Tallman	Gaylord, Kan.
L. A. Golden	Kensington, Kan.

STAFFORD COUNTY.

J. N. Rose	Stafford, Kan.
J. P. H. Dykes	Stafford, Kan.
G. W. Scott	Stafford, Kan.
Cyrus Wesley	Stafford, Kan.
John McDonald	St. John, Kan.
M. M. Hart	Macksville, Kan.
C. S. Adams	St. John, Kan.
F. S. O'Flyng	Seward, Kan.
P. W. Trethbar	Hudson, Kan.
W. S. Crouch	Stafford, Kan.
T. W. Scott	Stafford, Kan.

SHAWNEE COUNTY.

H. L. Alkire	Topeka, Kan.
Harriet E. Adams	Topeka, Kan.

WYANDOTTE COUNTY.

G. M. Gray Kansas City, Kan.
 R. A. Roberts Kansas City, Kan.
 P. D. Hughes Kansas City, Kan.
 C. M. Stemen Kansas City, Kan.
 R. C. Lawman Kansas City, Kan.
 S. S. Glasscock Kansas City, Kan.
 F. M. Tracy Kansas City, Kan.
 A. S. Paversh Kansas City, Kan.
 Martha M. Bacon Kansas City, Kan.
 W. F. Waite Kansas City, Kan.
 J. G. Poole Kansas City, Kan.
 B. F. Sharp Kansas City, Kan.
 J. F. Hassig Kansas City, Kan.
 J. E. Sawtell Kansas City, Kan.
 Anna K. Masterson Kansas City, Kan.
 B. M. Barnett Kansas City, Kan.
 John Troutman Kansas City, Kan.
 A. J. Lind Kansas City, Kan.
 O. M. Longenecker Kansas City, Kan.
 C. A. Foulks Kansas City, Kan.
 Jas. W. May Kansas City, Kan.
 C. J. Lidikay Kansas City, Kan.
 F. J. Lutz Kansas City, Kan.
 S. H. Thompson Kansas City, Kan.
 Hugh Wilkinson Kansas City, Kan.
 Preston Sterritt Kansas City, Kan.
 J. H. McGregor Kansas City, Kan.
 Thos. Richmond Kansas City, Kan.
 W. D. Fairbank Kansas City, Kan.
 J. O. Milner Kansas City, Kan.
 J. A. Fulton Kansas City, Kan.
 J. A. Davis Kansas City, Kan.
 L. F. Barney Kansas City, Kan.
 Jessie Newkirk Kansas City, Kan.
 F. P. Clark Kansas City, Kan.
 F. Campbell Kansas City, Kan.
 G. W. Richards Kansas City, Kan.
 J. W. Faust Kansas City, Kan.
 Z. Nason Kansas City, Kan.
 J. J. McCalman Piper, Kan.
 Ottaker Hoffman Argentine, Kan.
 G. H. Hoxie Rosedale, Kan.
 C. L. Zugg Argentine, Kan.
 L. D. Mabie Kansas City, Kan.
 A. T. Swan Kansas City, Kan.
 E. R. Tenney Kansas City, Kan.
 J. L. B. Eager Kansas City, Kan.
 D. M. Smith Argentine, Kan.

D. E. Clopper Argentine, Kan.
 R. C. McClure Argentine, Kan.
 G. L. A. Hamilton Kansas City, Kan.
 D. W. Thompson .. Kansas City, Kan.
 C. B. Stemen Kansas City, Kan.
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 M. B. Roberts Kansas City, Kan.
 J. G. Sheldon Rosedale, Kan.

WESTERN KANSAS.

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 C. S. Marsh Menlo, Kan.
 A. C. Gulick Goodland, Kan.
 F. H. Smith Goodland, Kan.
 W. J. Lewis Gem, Kan.
 D. R. Stoner Quinter, Kan.
 H. A. Straup Winona, Kan.
 W. M. Beaver Colby, Kan.
 D. M. Forbes Seldon, Kan.
 E. J. Beckner Seldon, Kan.
 C. D. Blake Ellis, Kan.
 C. H. Gillman Oakley, Kan.
 T. H. Howell Ellis, Kan.
 J. H. McNaughton Gove, Kan.
 E. D. Beckner Hoxie, Kan.
 C. W. Winslow Oakley, Kan.

WOODSON COUNTY.

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 H. W. West Yates Center, Kan.
 E. K. Kellenberger, Yates Center, Kan.
 G. W. Lee Toronto, Kan.
 M. D. Elder Pequa, Kan.
 B. F. Browning .. Yates Center, Kan.
 S. J. Bacon Yates Center, Kan.
 A. J. Lieurance .. Neosho Falls, Kan.

NO COUNTY ORGANIZATION.

J. A. Fuller Lane, Kan.
 W. S. Grisell Ransom, Kan.
 H. Z. Hissem Ellsworth, Kan.
 Geo. Nicholson Plains, Kan.
 M. S. Reynolds .. Yates Center, Kan.
 O. E. Smith Leoti, Kan.
 W. T. Fletnitz Dorrance, Kan.
 C. W. Rairdon Lewis, Kan.

THE GREATEST OF ANESTHETICS.

We are living in an age of advancement in medicine, as well as in all departments of life, and he who does not hustle today will wake up tomorrow morning looking into space and wondering where his neighbors are who were with him yesterday.

I have been very much interested in Dr. Abbott's recently discovered hypnotic anesthetic, i. e., hyoscine, morphine and cactin com. I have used it in a number of operative cases, with very satisfactory results. The anesthesia was perfect, except in two cases where, in addition, I used a very small amount of chloroform, which completed the anesthesia.

I had none of the post operative nausea which we so much dread following other anesthetics. In one case of weak heart, where I could not use chloroform, the heart's action seemed to improve while under the influence of this hyoscine, morphine and cactin anesthetic.

For about two years prior to using the H-M-C anesthetic I had been using hyoscine and morphine as a hypnotic and analgesic, with such excellent results that I felt that I was not properly equipped without hyoscine and morphine tablets in my hypodermatic case, but had never thought of its ever becoming an anesthetic.

I feel that the medical fraternity is under great obligations to Dr. Abbott for the discovery and careful preparation of this much-needed and greatest of anesthetics, that is proving such a boon to suffering humanity.

C. C. COCHRAN, Jacksonville, Ill.

—o—

Home-Made Buttermilk.

It is now within the power of every household to have an abundance of that refreshing and healthful summer (also winter) drink--buttermilk. To the present time no one knew of any source of buttermilk except from the buttermaker; but now-a days the butter maker does his work so well that the buttermilk is entirely deprived of the delicious little grains of fat which add so much to its food qualities as well as to taste. True buttermilk, made direct from fresh rich milk, within a few hours, of the finest flavor and taste, nutritious and more excellent than the article as originally known, can now be prepared in any kitchen. This is done by taking a quart of fresh, rich milk, adding a pinch of salt and about a

half-pint of hot water to raise the temperature of body heat, and lastly adding a tablet which contains a pure culture of lactic acid bacteria. Place all in a pitcher, cover with a napkin, and let stand for twenty to twenty-four hours at the ordinary temperature, and there is your perfect buttermilk. The tablets are made by Parke, Davis & Co., the pharmaceutical and chemical manufacturers of Detroit, Michigan, and are called "Lactone" or buttermilk tablets.

On the farm in the process of buttermaking the cream is allowed to sour spontaneously and is then churned. The souring is the lactic acid fermentation caused by lactic acid bacteria or ferments. The difference between the new and old process is one of method and not result. In the old, the lactic fermentation is waited for and expected to occur spontaneously, with disappointment sometimes. In the new, the ferment in pure culture is directly planted in the milk, and the desired fermentation is secured without fail. In Bible days, spontaneous fermentation of dough was depended upon to leaven or lighten bread, and failure frequently attended the process, the dough putrefying instead of fermenting, and was then lost. Finally, man learned to add yeast to the dough and not to depend upon spontaneous processes, with the result of always securing the right fermentation and making a better and more nutritious bread. This new buttermilk process is a like improvement—Monthly Bulletin Indiana State Board of Health, June, 1907.

—o—

H-M-C and a Happy Delivery.

A few days ago I was called to see a case of obstetrics. The lady was a primipara, twenty-four years old, was anemic, dropsical, with a very bad heart. She began having pains on Sunday afternoon, and I was called on Monday morning. She was having pains at intervals of five minutes but the os did not dilate. During the day and up to ten o'clock the pains grew stronger were very severe with but little dilation of os; patient almost exhausted. I gave one half size H-M C (Abbott) at 10 p. m. She was sleeping thirty minutes after and was delivered of a fine boy at 2 a. m. Complained some during the last three or four pains. I was delighted and so was the patient.

J. H. HAMMOND, Enigma Ga.

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APPENDICITIS.

By CHRISTIAN B. STEMEN, A. M. M. D. L. L. D., Kansas City, Kans.

It may be thought unnecessary for any surgeon to read a paper on a subject so very common, and so thoroughly understood by the profession in general, as the one that I have selected, but there are a few points that to my mind, should be more fully considered, and it is to some of these conditions that I desire to call your attention.

In regard to the history of appendicitis, much has been written. Dr. B. Merrill Rickets, Ph. B. M. D., of Cincinnati, Ohio, in June, 1901, gave to the profession through the Journal of the American Medical Association a very interesting paper from which we make the following quotation:

“Noyes, in 1893 collected 100 cases in which an operation had been performed; 90 of these were in the United States. Barlow and Godlee made, September 16, 1885, an exploratory operation to determine the cause of an abscess in the right iliac fossa. Pus was found about the appendix, which proved to be the seat of the disease. The pus was evacuated, but the appendix was not removed. Hall, on May 8, 1886, at 11 p. m., in operating upon a case in which he had diagnosed strangulated hernia, opened what he supposed to be a hernial sac of the scrotum, found the vermiform appendix, which he removed, enclosed in exudates and extensively swollen until it resembled a normal testicle in size and shape. An existing perforation was supposed to be due to tuberculosis, which was far advanced.

H. B. Sands, on December 30, 1887, diagnosed a case as acute septic peritonitis caused by perforation of the vermiform appendix.

Read at the Kansas Medical Society, Kansas City, Kansas, May 9, 1907.

He opened the abdomen and evacuated a pus cavity, trimmed the margins of the perforation off in the appendix and sutured them with silk. The appendix in this case was not excised. McBurney, on May 23, 1888, removed the appendix in a case in which Dr. W. K. Otis had diagnosed appendicitis. This is the first case in which an operator deliberately planned for and did remove a diseased appendix. Listers' great discovery of the principle of asepsis gave surgeons great encouragement to interfere in cases that had been previously thought hopeless. Then it remained for the magic hand of Lawson Tait to perfect appendectomy as he has all other operations upon the abdominal viscera."

The writer on the 21st of April, 1887, opened the abdomen and removed a ruptured appendix. The case was what was supposed to be general peritonitis and the attending physician having abandoned all hopes for the recovery of the patient, and so far as medical treatment was concerned, there was no prospects of saving the life of the patient. Only a short time previous to being called to this case I had the misfortune of having three cases of what was supposed to be general peritonitis, and all three cases died, and in holding a post mortem, found in each of the three cases a ruptured appendix with abscess in the right side in the region of the appendix which demonstrated to my mind that the diseased appendix was the cause of the general inflammation. I determined to give to this case the benefit of surgical procedure. The patient and friends accepted the suggestion; the operation was made, the ruptured appendix was removed and drainage employed, and the patient recovered, and is now living and in good health. The technique was crude and imperfect. We opened the abdomen in the median line; found great quantities of pus serum which was removed and drainage employed; used for this purpose a rubber tube. We of course in this case had to originate the technique. I have never claimed to be the originator of the operation of appendectomy in this country but was at least one among the first. Dr. Rickets stated in a subsequent paper to the one above referred to published in the Journal of the American Medical Association that the case above reported was the first made in the United States.

Dr. Deaver of Philadelphia, in his late and excellent work on appendicitis names the following surgeons who operated previous to 1890.

. Adams, Bacon, Bailey, Barlow and Godlee, Barret, Beach, Boardman, Bontecou, Briddon, Bryant, Buck, Bull, Burge, Byrd, Cage, Chamberlain, Chaput, Clarke, Clay, Cutler, Deaver, Ede-

bohls, Ely, Freeman, French, Fries, Gibney, Gouley, Grant, Hall, Heath, Hicks, Hoffman, Holden, Howe, Jarvis, Kelsey, Kohler, Kolb, Krockowizer, Leale, Lewis, Maclaren, Mason, McBurney, Merriam, Mikulicz, Miner, Moore, Morton, Mynter, North, Noyes, Partridge, Pierson, Pinkney, Polaillon, Poncet, Pooley, Potter, Post, Raub, Regnier, Stemen, Stiegle, Stimson, VanBuren, Vanderveer, Voss, Walker, Ward, Weber, Weinlechner, Weir, Wey, Whittall, White and Woodard.

When we consider that not more than twenty years have elapsed since the first operation for the removal of the diseased appendix was made in this country or in any country, and as surgeons know the thousands of valuable lives that have been saved since then, it is almost marvelous and beyond our comprehension. The results have been gratifying. We frequently find surgeons who sharply criticise the general practitioners of medicine for their delay in bringing cases of appendicitis to the surgeon or employing surgical aid. It has always been with satisfaction that I have observed the correctness of most of the general practitioners in making a diagnosis of this disease, but we should remember the great difficulty and embarrassment they have to contend with. First, it may be but a slight attack, and it is quite difficult to obtain the consent of the patient and friends to the removal to a hospital, or even the calling of a surgeon. A great many persons having quite a dread for the surgeon's knife and the hospital. Again our secular papers are filled with quack advertisement, claiming to cure appendicitis "without the knife." Under these circumstances the family physician has a very serious proposition on his hands, one that requires great tact, firmness and persuasion to get the consent of the parties to the calling of surgical aid. It has been my experience that the great majority of the general practitioners of medicine are standard men in the profession and able diagnosticians, and I have found them conscientious and devoted to their patients, and not any more liable to make mistakes than the surgeons. The laity is becoming better educated in regard to this disease, and if the surgeons and general practitioners will continue to labor harmoniously together the profession will not have the difficulties to contend with in the future that they have had in the past; in regard to securing early operations, and thus secure a larger per cent. of recoveries. It is well known to all surgeons that there is but little danger in the operation itself; the danger is in the condition of the patient; the variety of the disease under consideration; the severity of the lesion and the virulence of the infection. Another important factor is

the ability of the patient to resist the infection. Those of a gouty or rheumatic diathesis, those with diseased or inactive kidneys or of well marked alcoholic habits, or those with a super abundance of adipose tissue are prone to become victims to infectious processes, especially when the urine contains large amounts of albumen, and many casts showing that the kidneys are choked with bacteria; we should consider such a condition unfavorable, with or without operative treatment. Byron Robinson has stated that in 230 autopsies 70 per cent. showed evidences of chronic inflammation in the peritoneum about the ileo-appendicular region, showing that appendicitis frequently occurs, and is recovered from sufficiently to permit the individuals dying of other diseases. May not this chronic inflammation although apparently recovered from, have caused to a certain degree the other diseased conditions which finally resulted in death. It is the opinion of the author that whenever the appendix becomes involved in any form of disease that the effects are permanent, and will cause trouble in some form in the future. The symptoms of appendicitis as a rule are well marked, and yet there are cases where the very best diagnosticians are in doubt; other inflammations in the gastro intestinal tract are accompanied with pain and vomiting, and may be mistaken for appendicitis, inflammation and fecal impaction in the cecum, but this is a condition seldom found, but occasionally, the passage of gall-stones, with a distended gall bladder, passage of renal calculi, inflamed ovary, a purulent cyst of the ureter; tumor of the kidney or even a floating kidney may lead to errors in diagnosis, but a thorough history of the case and a careful and painstaking examination will enable us to make a correct diagnosis. In the treatment of appendicitis we have the medical and surgical respectively; much will depend upon the preconceived idea of the physician having the case in charge. Some physicians, as we know, will depend on the medical treatment, and are slow in recommending surgical interference. My experience warrants me in saying that the best results are obtained in at once removing the diseased appendix, that is as soon as the diagnosis has been made provided there are no complications that would make the operation unjustifiable or serious. All surgical operations are made for the purpose of saving life, or the correcting of deformities, and this rule should apply in cases of appendicitis, as well as in all other surgical cases. I would urge the necessity of an operation even in a case of appendiceal colic before the inflammatory stage in preference to having a case of perforated appendix with abscess, and the danger of general peritonitis. It is the con-

census of opinion of all surgeons who have had much experience in these cases that an early operation should be made. Those physicians and surgeons who favor the medical treatment exclusively, or who want to wait until there is absolutely no choice, but when an operation is "the last resort" are becoming less in number every year. Every surgeon and physician realizes when we must operate under such circumstances the chances for recovery are greatly diminished, then the disease has spread beyond the appendix, and the mortality from operation is greatly increased. While we acknowledge that a certain per cent of cases may and do recover without surgical procedure, and may have but one attack, yet the great majority of cases only recover temporarily, for no physician or surgeon can foretell when a case will terminate favorably, or go on to perforation, abscess or gangrene, resulting in general peritonitis and death. In my own experience I have had a number of cases bearing on this point, and it is for this reason that I have selected this subject for this occasion.

A few years ago I was called to see a young lady who had a slight attack of appendicitis. I then advised an operation, but the patient and parents thought best to wait awhile. She recovered, and was in comparative health for a few months, when she had another attack. I then insisted on removing the appendix, but could not get the consent of either the patient or her friends. The result was that in about six weeks I was called again, and found the patient with general peritonitis, and she was taken to the hospital and the operation was made "as a last resort," but the patient died. I could give numerous cases of a similar nature; of course not all of these cases proving fatal. I know that surgeons who have had any considerable experience in the management of cases of appendicitis have had much the same results. How easily the diseased appendix could have been removed, and without endangering the life of the patient at the time the diagnosis was first made, or during the interim, when there would have been a clear field, no pus or inflammation. The laity frequently say that the surgeon is only too ready to operate, but my experience is that no good, conscientious surgeon will operate unless he believes it to be for the good of the patient. I have too exalted an opinion of the members of the honored profession to believe that any surgeon would open an abdomen only for experiment, self aggrandizement, or for mercenary motives. Can I benefit the patient by an operation? Is the only question to be considered, and is the only motive that should influence the surgeon. I am certain that the number of surgeons who oper-

ate for any mercenary or selfish motives is very small.

We cannot foretell with any degree of assurance the result of an attack of appendicitis, neither can we tell to a certainty the nature of the lesion of the appendix, for my experience has taught me "that every case is a law unto itself." No two cases are just alike, either in the symptoms or lesion.

The point that I wish to emphasize is this: in cases even of slight attacks shall we risk the patients life, or shall we adopt the best and most certain treatment, and remove the diseased appendix even though the inflammation may be very slight; my judgment is that this procedure is the safer and thereby more conservative.

We cannot be governed by the same reasons that we are in cases of tumors; the correcting of deformities; the radical cure for hernia, or the removal of a fibroid from the uterus, etc. In appendicitis no matter what the lesion may be, we have a serious condition; as stated before the patient may recover, and not have any more attacks (but this in my experience is very seldom) but is more likely to go on to suppuration, gangrene, perforation and abscess, resulting in general peritonitis and death. Can we conscientiously take such risks for our patients? I think not. Operate early; immediately after the diagnosis is made. Do not delay, if the patient and friends refuse the proffered aid, you as a medical man, have done your duty, and the responsibility is with them. I remember a very excellent country physician who advised an operation for appendicitis in a case where there was but a slight attack, when he was discharged and a fellow practitioner called to see the case, who advised medical treatment. The patient recovered temporarily, and the first physician was held at quite a disadvantage in that community; but only for a short time, when the second attack came on and before a surgeon could see the case general peritonitis developed and the patient died. This demonstrates the necessity of great care in the management of all cases of appendicitis. Delay is dangerous in the great majority of cases. As stated before some patients will recover from the disease without an operation, but no one is able to say positively what the result will be, consequently, an early operation should be insisted upon by every physician and surgeon. My experience is that those who are least decided upon the question of immediate operation, are those with but a limited experience, for certainly no one having had an extensive practice in this class of cases, but what would advise early operations in all cases of appendicitis. I would not

insist where the case shows an undoubted tendency towards localization (and yet it is dangerous) immediate procedure, but in such cases the best judgment must be exercised, for even in such a case we have the risk of general septic infection of the peritoneum, resulting in abscess of the liver, phlebitis, fecal fistula, etc.

Dr Deaver, in his late work, makes the following statement:

“In the light of an extensive personal experience—several thousand cases—the principle may be stated; That in every case of appendicitis, seen early, operation is indicated regardless of the mildness of the attack and regardless of the severity of the attack (in the absence of a spreading peritonitis).”

While we urge the necessity of removing the diseased appendix immediately after the diagnosis is made, I am not unmindful of the fact that there are many circumstances that interfere with this being done at once. The patient may not live near a competent and skillful surgeon, or the family may not be willing to have a surgeon called, and will insist on waiting until there is no other chance. Again, there may be some serious complications forbidding surgical procedure. Under such circumstances the medical attendant has no other alternative but to give the patient the best medical treatment, and the physician should not be censured for doing all that he can. The medical treatment best suited in an acute attack should be absolute rest in bed, and, I mean by this, not to move about in bed, but be quiet; should abstain from food and drink; no food at all for several days, and drink as little water as possible. Should make use of the bed pan and urinal: the object should be to give rest to the alimentary canal; not to increase the peristalsis. If vomiting is present small doses of calomel with bicarbonate of soda may be given not in sufficient doses to act as a cathartic. Morphia, or opium is recommended by some good physicians to relieve the vomiting and pain. I would not recommend any narcotic, unless the pain was very severe. I would recommend the application of the ice bag over the region of the appendix, or if there is some complication contraindicating the use of ice, I would employ hot applications. One of the great mistakes made in the treatment of this case is the giving of nourishment, and in fact it is not good practice to feed any sick patient. I have allowed patients to fast from 24 to 48 hours, and then give nourishment by enemas from six to eight ounces of milk peptonized for half an hour with the whites of two eggs, and a half ounce of brandy; some preparations of beef may be substituted for the brandy. This may be diluted with a pint of the normal saline solution, and may be

given every six hours. After convalescence has been established the return to taking nourishment should be gradual, and guarded. I should have stated before that while it is improper, or in my opinion, injurious, in many cases to give a laxative, yet where I believe that there is indigestible food in the alimentary canal, I would advise a saline cathartic especially if the patient is to be operated on at once. I always feel safer if I have had the bowels emptied, but understand me, where the case cannot be operated on and the diseased organ removed, then I would not give a cathartic. I should not enter into the discussion of the surgical treatment only to say that there is no danger in the operation itself; as stated before, the danger is in the condition of the patient. I am frequently asked in regard to the danger of operating on the young infant, or persons of advanced years. The only answer that I can give is in my own experience. The youngest patient that I have operated on for appendicitis was four years old; was a bad case; appendix ruptured and an abscess, but made a good recovery. The oldest was a man in his ninety first year. The appendix was gangrenous, and he made a good recovery. Age is no barrier to operation. I would advise in making an operation for the removal of a diseased appendix, careful antiseptic precautions; in fact in all surgical operations the surgeon should carry out in detail the antiseptic precautions.

I trust that this paper will be received in the same spirit in which it is given; the writer's only desire being to bring before the profession a few points that should be more fully understood, and in the belief that if carried out will save many valuable lives, and bring comfort and satisfaction to the members of our noble and honored profession.

DISCUSSION.

Dr. Stillman:—I recommend that as many copies as possible of this paper be distributed, when it is published.

Dr. Mitchell:—I want to report a case of appendicitis. I was called about fourteen miles in the country. Some one telephoned me for medicine for colic. I sent something out. The man came in the next day and said the colic was as bad as before. He said he would try taking some medicine out to the sick girl, and if the patient was not better by the next day, that I had better come out. I went out and found a girl fourteen years of age suffering from a severe attack of acute appendicitis. The father who was a stern farmer, said: "Keep your head, young man. When that girl dies, she will die all together." My urging an operation was to no avail. We did the best we could. I saw her every other day. Then, about the tenth day I found a large hunch on the right side. I knew what we had. Again I urged an operation, but was refused. The man said for me to go ahead and treat her without operation; and, if she died he would not blame me.

I saw her every day. This bunch became larger. I told them the bowel was full of pus. About the 17th day I was called hurriedly; and, when I reached the house they told me that the pus had come up and the girl had expectorated about one quart of purulent matter. The young lady made a recovery after this. Her temperature went down and by the 23rd or 24th day she was feeling real well. She is living today.

Dr. Brookhart:—The doctor spoke of recovering from appendicitis and then dying (apparently) from some other cause, which might be traced to appendicitis. To illustrate: Last winter I was called to see a case of appendicitis. I recommended an operation, but was refused. I treated him, and he apparently recovered. This year he was injured on the fingers by a machine. He came to the office and was treated aseptically. He complained of a great deal of trouble from those fingers—finally had them amputated. He died. At the autopsy, a cold abscess was found in the left iliac region that had lain there for a long time. The young man died as a result of it.

Dr. Young:—I have not spoken before in this body, and I do not want to begin by criticising so old a man as Dr. Stemen. A recent visit to the Mayo brothers has given me a little idea that may be of value to us. Above all things, the Fowlers position, is maintained throughout the entire treatment in St. Mary's hospital. The Fowler's position is the main thing on which dependence is placed, aside from surgery. Another thing—a drop of water in the alimentary canal starts a peristaltic motion that is not stopped until it reaches the appendix. These doctors say that they should be treated (if not seen until the fourth day) by placing in the Fowler's position; second, withdraw all medication and all food; and, do not operate too soon. Do not jump in and operate the first thing when you see the patient at the third or fourth day. They depend a great deal at St. Mary's on the normal salt solution. They obtain it by placing an ice bag above the patient's head, and using a douche tube, let it drip down about a pint per hour. A gentleman asks me what is the Fowler's position? It is placing the patient in upright position, as pus in the lower part of the abdomen is not considered so dangerous.

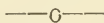
Dr. Jones:—The doctor who referred to the Mayos might, by his quotation, give the impression that they delay in their operative procedure. I believe that delay is one thing that has been productive of a great deal of harm in these cases of appendicitis. Neither one believes in waiting for anything except a fair condition of the patient. I asked Dr. W. J. Mayo what he thought of the leukocyte count in a case of appendicitis. He said that he believed in it; but, the best place to get it was on the operating table. They did not use the Fowler's position, except in their pus cases. One thing I am glad that Dr. Stemen did not dwell on is the leukocyte count. I believe it has been productive of harm. I believe that if you have a case that has a fair pulse rate, you can time your operation by other clinical evidence. I use the leukocyte count, but think that it should not be depended on to the exclusion of other evidence.

Dr. Hughes:—I wish to say a word along the line of thought suggested by Dr. Jones. An eminent surgeon has said that in watching a case of appendicitis, there comes a time when the appendix ruptures; then, if you get to that patient within five hours, you can do something. If you do not get there in that time, you had better wait.

Dr. Stillman:—How do you know these acute symptoms are going to subside? How do you know that the phagocytes are going to take away this debris? How do you know that an operation at any time, removing the original focus of infection, will not help that case? The earlier operation, seems to me, would be the thing indicated. With some eight or ten cases, in my experience, operations have been successful.

Dr. Walker, Salina:—I enjoyed the doctor's paper very much, but there is just one thing I should like to see the doctor cut out; that is, not to give anything but a little water by way of the stomach, and never a saline laxative. If he would cut that out, I believe the paper would be absolutely perfect. I am afraid to give anything by the stomach. If you allow a little, they are going to carry it too far. If the doctor himself could attend the patient at all times, it would be all right.

Dr. Stemen:—Mr. Chairman, I have but little to say. I was very much interested in the discussion. The illustration given shows just the danger and the condition in which we find so many patients. I have always been considered a very conservative surgeon. I have always been conservative in everything, but I insist on the removal of the appendix whenever you find it inflamed. In teaching a class, which I taught a good many years, I used to ask this question: What is the best treatment for appendicitis in the first two or three hours? They would give various answers, and good papers; but, after complimenting them on their work, I would close by saying: The best treatment is the removal of the appendix. I was called recently to see a case. The young man would not be operated on. I told him he must get some one else. He wanted me to give him some medicine. I told him, "I know of no remedy for you but the knife." He would not have an operation. I told him to get some one else. I could not treat him. I went on to the hospital. In about one hour and twenty minutes he had made up his mind to have an operation. We operated. It was a very serious case, and a difficult one. He could not have lived. He is getting on very nicely. One of my sons is now in Bethany hospital, having been operated on for catarrhal appendicitis; the other one has had his appendix removed. So, I have been practicing the Golden Rule. The safest practice is to remove the appendix in the slightest affection, because if not you will have, as a rule, a recurring attack.



The distressing thirst after abdominal operations, where fluid by mouth produces vomiting, is best relieved by subcutaneous infusions of normal salt solutions; or by the insertion of a tube into the rectum connected with a bag of saline solution placed just above the level of the patient's hips, allowing the injection of water drop by drop and so slowly that no irritation of the rectum is set up. The patient may in this manner receive small quantities of water for hours.

PLASTIC GYNAECOLOGY.

By N. C. SPEER, M. D., Osawatomie.

An apology for presenting a paper upon the time-honored subject of "Plastic Gynaecology" is perhaps in order, but the fact that more physicians could and should be doing this class of surgery, justifies its presentment. My further explanation for presenting this subject is, that until recently, I have been associated with the Osawatomie State Hospital as a member of the medical staff, and have had considerable opportunity for observation along this line.

This branch of work engages the attention of physicians who do, largely, an office practice, because they deal with those patients who make weekly visits for local treatment, but who do not thus recover their normal health. I shall deal with secondary operations upon the cervix and perineum, directing attention to a few points in diagnosis, but especially to the method of operation and after-treatment. These operations, when proper care is exercised, meet with marked success—the patient who has had the perineal lesion regains her strength; the one who has had a cervical lesion, is freed from endo cervicitis with its attending symptoms, and the need for palliative treatment ceases. Those cases which are usually diagnosed as not of sufficient gravity to need repair will receive my special attention.

Etiology of Perineal Lesions. Few words are required to cover this phase of the subject, for the cause is very frequently hasty mid-wifery, but still more often, untimely departure from the lying-in chamber leaving the deeper lacerations in the vaginal walls to unite without surgical assistance, under the supposition that nature cares for them. If they were promptly repaired the puerperium would be shortened, the rise of temperature obviated, and the pain so annoying to the patient, absent. These hidden injuries are most treacherous and invite the closest attention of gynaecologists. As to the cervical injuries, they are probably made Pathologic by too much manipulation, in other words, by meddlesome mid-wifery; nature usually accomplishes dilatation. The temptation, however, is great to aid the suffering patient, and charity should be shown the sympathetic obstetrician.

Diagnosis in Perineal Cases. In case there has been little division of the skin surface of the perineum, it is with difficulty that a

laceration can be diagnosed, especially so if the puerperium is over, and the torn surfaces are covered with new tissue. These patients, when placed in position for examination, usually make resistance, either from pain or modesty, and when they are aided by the perineal muscles, the canal seems to be normally closed. If it were practical to anaesthetize for diagnostic purposes, fewer errors would be committed, because then, a truer state of affairs would exist, and if there were either a cystocele or rectocele, it would present itself.

In the usual office case, it should be ascertained if there be any evidence of cicatricial bands along the posterior or lateral walls, also, if there appears a cystocele or rectocele; the latter condition is *prima facie* evidence of laceration. Possibly if these precautions were taken, there would be less demand for the various operations for uterine fixation. The symptoms of which the patient complains should receive credence in making a diagnosis.

Diagnosis in Cervical Cases. A very high percentage of the cases of endo cervicitis are chronic lacerations. The cervix presents, in these conditions, a surface closely counterfeiting the normal; the lips have either partially atrophied, thus causing eversion, or the cicatrix has become hypertrophied, leaving in either instance practically a normal appearance. A portion of the anterior and posterior lips are thus covered with the normal lining membrane of the cervical canal; the cicatrix is covered with a new layer of epithelium, unstable and vulnerable; both being varieties of membrane abnormal to the vaginal canal and its secretions. This leaves an organ poorly equipped to withstand the pathologic processes which will follow when conditions are promising.

Usually when the case presents itself, it is found that the cervix is hypertrophied both from inflammation and tissue changes, and the surface partially eroded; accompanying this, is a uterine discharge. Appropriate treatment removes the inflammation, and, in a few days or weeks, it is supposed the patient is cured; but the conditions, which brought on the former attack, exist, and in a short time there is a recurrence of the symptoms. In order to demonstrate that the afore mentioned conditions exist, grasp the everted lips with sharp tenacula, draw them downward and together; if they coapt and form a proper shaped cervix, the diagnosis is assured. This would occur if the inflammation had subsided and there was simply retraction; but, if there should be considerable inflammation or an abundance of cicatricial tissue in the site of the laceration, it would be impossible to thus demonstrate it. Unilateral lacerations are quite frequent, and the left cornu is the one

most affected; these unilateral tears give the patient less inconvenience than the less grave bilateral varieties which have retracted.

Treatment. Preliminary treatment should be instituted to the extent that the inflammation is removed and the uterine discharge checked. Provided that there is an endo-metritis which will not succumb to local measures, a curettement may be done at the time of the operation, but better results may be expected when the inflammation and congestion have disappeared. Alteratives and re-constructives should be faithfully administered during the whole period, as a healthy body hastens surgical convalescence, and these patients are usually in need of such treatment, because of their prolonged ill health.

Treatment Incident to Operation. On the evening previous two tablespoonfuls of epsom salts should be administered—an experience with other purgatives will bring favor to the salines,—an enema in the morning is unwise because a certain quantity of water will be retained and expelled at intervals during the operation. Before administering an anaesthetic, it is often well to permit the patient a small drink of water, for the fluid in the stomach counteracts the anaesthetic they may swallow.

The anaesthetic is then given; the parts are scrubbed, using a liquid soap, shaved and thoroughly doused with a bichloride solution 1-2000. For either a perineorrhaphy or trachelorrhaphy, the preliminary technic is practically the same.

Trachelorrhaphy. Having the patient in the lithotomy position, expose the cervix with a Simm's speculum, grasp the anterior lip with a vulcellum forcep, insert in the median line a strand of large raw cat-gut. In a similar manner, treat the posterior lip. These strands are more easily manipulated in holding the uterus in place than forceps, and do not readily become detached. By using ordinary force, the uterus can be brought into plain view, when the patient is anaesthetized; after the influence of the anaesthetic is past, it quickly returns to its proper place.

The strands being inserted, instruct an assistant to hold one, the surgeon holds the other; separate the lips by slight traction, then with the hawk-bill cervical scissors, remove the cicatrix, from the two angles; this being done, take the strands alternately and denude the mucous membrane from each lip, always holding the strand that is attached to the lip upon which you are working. Be conservative in leaving sufficient mucous membrane to establish a canal.

The hawk-bill cervical scissors may not appeal to the scientific

mind, but in practice, they are eminently satisfactory, giving a clean angle that coapts accurately, and removes the cicatricial tissue thoroughly as well. In denuding the mucous membrane, an angular scissor is practical. All shreds of mucous membrane should be studiously removed from the denuded area, as it is a foreign body when union is taking place.

The uterus being under the control of the operator, it is easy to draw the cervix to either side and introduce the sutures, using a rather short, half-curved needle to carry them. The character of the suture material depends upon what is to be done; if both a perinael and cervical operation is to take place, it is well to use chromocized cat-gut in closing the angles, and silkworm-gut for the terminal suture. This is advisable for the reason that a tender perineum should not be subjected to rough manipulations, which will surely take place to an extent, in removing a number of silkworm gut sutures. Silkworm gut, which should be shot, holds the os tightly closed, and the cat gut will last the required period. These silkworm sutures should remain in place twenty one days and the cat gut will disappear without removal. But if no perineal operation, silkworm should be used throughout and shot compressed over the tips.

Perineorrhaphy. Operations upon the perineum are not uniform, no two tears are in the same location or of the same extent; thus principles are to be considered only in making this operation. The operation introduced by Lawson Tait can be done, after a manner, in every case. It is the flap-splitting operation and preserves the flap; it has the advantages, that it is easily done and leaves no place for infection to enter the vaginal canal; but as Dudley says there is an effort to improve on nature; it unites tissue that was not formerly united, makes the perineum thicker and the vaginal canal smaller than normal; thus the result is pathologic.

Probably if it is desired to follow a classic operation, the Emmet would be more practical. A simple method is to search the sites of injury, denude the areas, and, by deeply inserted sutures of silkworm gut, close them. The denudation can be done by dissecting a flap and clipping it out over the required area; or, by scissors, remove the mucous mebrane; the dissection, however, is easier and safer.

A wise precaution, when denuding and sewing, is to have a finger in the rectum to be sure that it is not being trespassed upon, either by a cut or by a needle thrust. There is probably only one reliable suture material for perineal work, and that is silkworm gut.

The needle used should be heavy and full curved; the light-weight needle will break easily. The skin surface should be closed with the same material; all sutures in the perineum should remain fourteen days; but if the cervix has been repaired, they may stay twenty-one days, in order to protect the newly healed tissue from being separated when using a speculum to remove the cervical sutures; it is possible that the tissue would hold without this precaution, but I have seen no inconvenience in leaving them that period, except that they become more deeply imbedded.

After-treatment for Perineal Cases. In restless subjects, and those who have not fully regained consciousness after anaesthesia, a knee-binder should be used; but, in the ordinary patient, it is unnecessary and causes annoyance and unnecessary muscle cramps. The secretions demand the most attention during this period. Catheterization is rarely necessary, but if it becomes so, there should be no procrastination, because delay may be disastrous on account of producing restlessness. The use of the bed-pan should be encouraged if it is found possible; but, if not, the upright position is permissible, provided that the knees are secured together to prevent separation of the parts. The bowels rarely act before the third day; if there is no action by that time, a laxative should be used, followed in a few hours by an enema, composed of sweet oil and water to the amount of one pint. The oil dissolves the scybalae, which may, if not broken down, do injury to the perineum. The daily use of mild catharsis should be continued, as constipation is frequently persistent, caused by the enforced rest and the perineal wound.

Cleanliness must be observed; the parts should be washed gently after each bowel or kidney action, and a pad of antiseptic gauze applied. Douches, composed of bichloride solutions, should be given once daily, unless their administration is too annoying and painful; then, they may be dispensed with entirely.

After-treatment of Cervical Cases. These are very simple to treat. If the field has been thoroughly cleansed after the operation, there should be little danger of infection, and if the sutures have been well tied, there will be little opportunity for infection to enter. The secretions may be regulated as indications arise. The subject of the douche is in question, as the result is equally good, whether or not it is used. A gauze packing or a powder application should not be used in the vagina on account of irritation. A recumbent position should be maintained two weeks, and a very careful existence for another week.

Remarks. These are principally repetition, but I consider them important.

The uterus can be brought into favorable position by slight traction and with no ill after-effects.

Cervical atresia is rare; little fear should be entertained for that accident; ordinary care, only, is required.

It is not wise to introduce a sound to ascertain the condition of the cervical canal after a trachelorrhaphy, lest some injury may be done; neither is it wise to insert a strip of gauze to keep the canal patulous.

The most substantial and satisfactory suture material is silk-worm gut, and it should be used in every case unless especially contra-indicated. I have never seen a case of non-union of the cervix, when it was used, but I have, when cat-gut was used exclusively. The closure of a vaginal fistula, either vesical or rectal, can be made substantial, when this suture is used. They should be introduced deeply and close together in such cases.

As very little pain is experienced when the cervix is being operated upon, only light anaesthesia is required; thus, patients with heart lesions may be easily subjected to this operation. Not so, with the perineum; deep anaesthesia is demanded.

The hawk-bill cervical scissors have been generally discarded by experienced operators, because they remove too much normal tissue, but to the physician who only does an occasional trachelorrhaphy, they answer well, they cut deeply and remove all the cicatrix, which an inexperienced operator fails to do.

Strict asepsis cannot always be observed but antisepsis should be; when cleansing the wound preparatory to tying the stitches be certain that no blood-clots are enclosed to form a nidus of infection or non-union.

The purpose of this paper has not been to teach experienced operators but to impress upon physicians who have not undertaken this class of surgery that it is possible that it be done successfully at home and that there is a crying need in every community for it. It should be a matter of regret instead of satisfaction to any physician that he has a large office practice devoted to palliative gynaecology. These patients can be easily cured.

DISCUSSION.

Dr. Hamilton:—I do not wish to discuss the paper, exactly, because, I was not here at the beginning; but, I do not think that we should pass over a paper without discussion. I think well of that paper. It has done

justice to the subject. It has pleased me very much to hear the part that I have heard; and, I think the action taken in the case outlined is very proper. I think this is a paper that should be interesting to all of us practitioners; and, we should give more attention to this subject; and have far more general discussion.

Dr. Hood:—I suppose the specialists all getting out makes a paper of this type less likely to be discussed. But, it was not intended for the specialists; but, for us common fellows in the country. I think it applies very nicely to us who come from the smaller places, giving us the idea that we should apply ourselves not to the palliative treatment of these cases, but to the surgical treatment of them. It is possible for us to do this work; but, we are very ready to continue with the palliative treatment rather than to take up the surgical, possibly from a timidity. Of course, his paper was on the surgical part altogether. We should not forget the prophylactic part of this and the fact that we who are in the country doing obstetrical work are to blame if we allow these things to become chronic. We should repair this work when it first occurs. Of course, when a case comes to us, we like to say that we are not responsible and lay it onto the other man. However, we can repair the other man's work. I repeat, that this paper was for the general practitioner and not for the specialist, and I appreciate it.

Dr. Speer:—I have nothing further to say except to emphasize the fact that in every man's practice he has every week a number of patients who come to his office, that if the cervix were investigated he would find that many of the various troubles are due to lacerations. If this were looked into, the os more nearly closed, the cicatricial tissue removed, etc., there would be less of these chronic ailments that come to our office and are not diagnosed

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Health in the Canal Zone.—It is reported from Washington that very great improvement has taken place in the sanitary conditions in the Canal zone, with a corresponding reduction of illness among the canal workmen. With 10,000 more men at work, there are fewer sick this year than there were last.

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Alcohol in Treatment of Consumption.—According to the statistics in the report of the Henry Phipps Institute for the study and prevention of tuberculosis, alcohol neither prevents nor cures tuberculosis; neither does it strongly predispose persons to the disease, as is evidenced by the preponderance of non-alcoholic patients applying for treatment.

A FEW REMARKS ON PROPRIETARY MEDICINES AND THE RELATION OF DOCTOR AND DRUGGIST.

By LLOYD A. CLARY, B. S., M. D., Winfield, Kansas.

I hesitate to read a paper with the above title for the proprietary medicine question is one of large dimensions* and one which has been thoroughly discussed in our journals and before our societies for many months past. It is a subject not at all new to any of our members, and one which can be only briefly treated in a paper of this kind. "The Relation of Doctor and Druggist" has been the subject of numberless talks, discussions and papers recently and should be a settled subject and one requiring no more agitation. Yet the relation existing between these two professions are not nearly so harmonious as they should be, and any effort made to better conditions will not be wasted energy. I have taken up the proprietary question in this paper not because it is a small one and not large enough for separate discussion, but simply because it is so intimately connected with the doctor-druggist problem.

Firstly, let us take up briefly the evils that have arisen from the prescribing of proprietaries and try to determine who is responsible. In this connection we do not refer to those New and Non-Official Remedies that have been approved by the Council on Pharmacy and Chemistry of the American Medical Association, nor do we refer to those elegant pharmaceutical products that have been offered to the profession by such houses as John Wyeth and Brather, Frederick Stearns and Co., etc. We mean the nostrums and preparations that have been put out in great numbers by more or less unscrupulous makers, promoters or distributors, simply as a money making proposition. Take the notorious Antikamnia for instance. Who is responsible for this name being a household word and for the thousands of people who buy Antikamnia at the pharmacy for their own use? Is the druggist responsible? Or is the careless doctor to blame? He who prescribes the little tablets with their "AK" stamped prominently upon them, not knowing what he prescribed and thus placing in the hands of the laity and endorsing to them a veritable "patent medicine"? We have heard doctors in our county society meetings endorse Abbott's Saline Laxative. Do you find this preparaton among the pharmaceuticals on the

Read before the Cowley County Medical Society Sept. 12, 1907.

druggist's shelves? No, it stands out boldly among the "patents" and is sold as such. Do you know what it contains? Do you think it just and fair to the patient to ask him to buy a can of this stuff at 50 cents when the label boldly proclaims it to be 60 per cent magnesium sulphate in effervescent combination? Why not prescribe magnesii sulphas effereescens, U. S. P., under its own name and have the druggist put it up and dispense it at better profit to himself and at a saving to your patient?

Some of us recently received samples of labordine and anasarcin just after they had been fully exposed by the Journal of the American Medical Association. Did we use these free medicines and prescribe more? Or did we consign them to the waste basket?

About two months since the detail man for the Maltine Company called on us at our office and left us a nice large bottle of Maltine and also a bottle of Neoferrum. Did we throw away this stuff? That would be a shame wouldn't it to destroy such a nice lot of free medicine. Perhaps though, we didn't destroy it, but handed it out to try it. But if we had opened up the Maltine package and noted the peculiar, distinctively shaped bottle with the name "Maltine" blown into one side and the red-lettered "patent medicine" circular enclosed, we would have hesitated before giving it out. Or if we had looked into the package of Neoferrum and noticed the name "Neoferrum" standing out in large letters upon the side of another distinctively shaped bottle and with the cork, the name "Maltine" stamped in it, capped with the Maltine design, we would have hesitated again. Then, also, if we had stepped down to the drug store and looked along the shelves among the other "patent medicines" we would have seen, standing out in bold relief the names "Neoferrum," "Maltine," "Maltine With Cascara Sagrada," "Maltine With Pepsin and Pancreatin," etc., on a dozen bottles extending across one whole shelf.

How many of us have written prescriptions for Bromidia, which is now sold by many druggists to whoever calls for it? This preparation contains, according to the manufacturers, fifteen grains each chloral hydrate and potassium bromide and one eighth grain each extract cannabis indica and extract hyoscyamus per drachm and is now made up according to this formula by some druggists to supply their retail trade. They have a large sale on it (at 25 cents per ounce) and many nervous individuals and "booze fighters" buy and use this product daily. Does this look like a very safe household remedy? Are we not to blame for this demand that has grown up for a very dangerous preparation? These instances

will suffice, I believe, to show that we, as a profession, are really to blame for the abuses of the proprietary medicine business to a very large extent and vastly more so than the pharmacists.

Now this is one legitimate cause for complaint the druggists have against the doctors. Let us look at some others. The owner of the drug store claims, sometimes, that we doctors shouldn't carry any medicine and should write prescriptions altogether. A liberal, broad minded pharmacist will make no such statement for he will realize that we must have medicine in our offices and in our cases for emergency work; that when we drive into the country to see a sick child we should not be required to call the hardworking father from the field to drive his tired work horses to town to get a prescription filled. He will realize that the poor patient who comes to us with a cold or a headache or some other slight ailment and with only 50 cents or \$1 in his pocket, should not be charged 50 cents or \$1 for prescriptions, which he must then have filled, for the strain on his pocketbook would be too great. This thoughtful druggist also knows that in an old, established community, there are scores of people who absolutely refuse to change the old order of things and who insist on the doctor furnishing the medicine. One argument of the druggists for prescription writing is the fact, as he claims, that the doctor will use inferior drugs if he dispenses. I believe a conscientious practitioner or one who cares for his reputation or success will not knowingly be guilty of this offense. Nevertheless most physicians are not well versed in pharmacy and do make this very mistake. A real, valid objection to dispensing is the great chance of the doctor getting in a rut and dispensing in a routine, thoughtless manner. We should know absolutely what we want to use and should see the patient gets it whether we dispense or prescribe.

The druggists say that we do not use the proper care in the writing of our prescriptions. In many cases they are right. They also say that we continually ask them to get new proprietary remedies which we may call for once or twice and which they then are forced to carry as dead stock. This is true and we deserve to be censured for this real offense against the good nature and financial condition of the druggist. We may easily remedy this fault by the use of the United States Pharmacopoeia and National Formulary in prescribing and thereby benefit ourselves as well as our pharmaceutical friends.

Now for a glance at the other side—the physicians' grievances. At our last county society meeting, when our sister society, the

Cowley-Elk Association Retail Druggists was our guest, we had a talk from the Ex-President of the Kansas Pharmaceutical Association on "The Relation of Doctor and Druggist." It seemed to me our discussion was not carried out to the extent it should have been at that time and we said very little for ourselves and heard practically only the druggist's side of the question. Some of our overzealous and enthusiastic members talked inspiringly about the "patent medicine evil" and how to eradicate it and about such rank nostrums as "Virgin Oil of Pine," "Barkola," etc. As for the "patent medicine evil," "The Great American Fraud," I don't believe we should score the pharmacists too heavily along that line for they are not the responsible ones—they are simply supplying a demand which will continue to be a demand for years to come. They cannot "cut out" "patents" and it is needless to ask them to do so for a certain class of people will persist in dopping themselves with nostrums as long as medicine is manufactured and sold. The majority of druggists, especially the more intelligent ones, do not like the "patent medicine" business and are not proud of it, but handle that trade through necessity. As for "Virgin Oil of Pine," "Barkola," etc., we cannot blame our drug stores for handling the abominable stuff for they have again a demand which they must meet.

Another point touched upon by our society members in this discussion was the advertising of "patent medicines" in our daily press, the advertisements appearing over druggists' names and purporting to be endorsed by the druggist. This was and should be severely condemned, as it places the druggist in the position of advocating and pushing nostrums while he tells us he despises them and that he wants our prescription business. It looks as if the druggist were trying to build up a good paying, legitimate prescription business by asking us for our patronage and pretending to treat us fairly while at the same time, he is striving to increase the "patent medicine habit" and thereby undermine and destroy the doctors' business. On the face of it this doesn't look like good business judgment, though perhaps the druggists haven't viewed the subject in that light. However, here again we must not condemn our druggists too severely for the evil we speak of is not a local one but prominent all over the country and the remedy lies in first freeing our press from this obnoxious class of advertising. This will be very difficult to accomplish, but when it is accomplished the pharmacist will then have no incentive to lend his name to "patent medicine" advertising for his competitor will also be silent upon that subject.

The tie which binds us to the druggist is that small paper called a prescription blank. This is—or should be—simply an order on the druggist for a certain preparation with instructions as to how he is to dispense the same and as to the directions he is to put upon the label. It is over this small but mighty prescription that the main trouble rises. Physicians have three main causes for complaint against pharmacists, namely:—refilling, substituting, and counter prescribing. We have submitted to abuses along these lines for many years. Our professional brethren have other difficulties of minor importance and of local nature, or occurring in isolated cases, such as the exploiting of physicians prescriptions by pharmacists; pernicious activity in the pushing of various “patented” products; the boosting, by a druggist who is patronized by many medical men, of one particular friend in the profession, and so on. But we won’t take time to discuss these abuses.

Of the three main troubles mentioned let us first consider refilling. By this we mean the refilling time after time of a prescription and not the ordinary custom of the second or third refill which is done with the consent of the prescriber. A few illustrations may not be out of place. A certain doctor in a certain town on entering a drug store one day met a farmer coming out with a bottle of medicine in his hand. The farmer said to the doctor, “That is the best medicine for rheumatism I ever used.” The doctor asked what it was. “Why, you ought to know,” said the farmer, “it’s one of your prescriptions.” “I never prescribed for you”, answered the M. D. “No, but you did for my neighbor, and I borrowed his bottle,” was the reply. Is it any wonder that doctor dispenses his own medicine now? One instance I know of where a whole neighborhood used a prescription for a cough mixture winter after winter for ten years—and may be using it yet for all I know to the contrary. Now this practice of the druggists of refilling a prescription for an indefinite period is not right and we should vigorously protest against its continuance. Druggists, to my positive knowledge, have filled, time and again, prescriptions with the words, “Do not refill” or their Latin equivalent, printed plainly on the blank. One druggist said to me, “Why, we don’t pay any attention to that,” and he went on to say that if the doctor had WRITTEN the words, “Do not refill,” or had UNDERSCORED the PRINTED words, he would then have given them some consideration. The druggists seem to forget that a prescription is simply an order for a certain quantity of medicine to be dispensed to the patient once and only once. They do not stop to think that what was appropriate for the

original illness or trouble very likely is not the proper treatment for a subsequent illness or even for a prolongation of the original sickness. The ideal condition would be one in which no such phrase as "Do not refill" would be necessary and in which the druggist would lay aside his mercenary desires and refuse to do a wholesale filling business. Here is another condition which can be remedied to some extent by the physician who has been imposed upon. He can insist upon his prescriptions going to a man whom he knows to be honest and ethical.

The so called evil of substitution is a much less prominent evil and one which has been overestimated by some of our profession. This abuse does exist it is true, but not to any appreciable extent among the better class of pharmacists and for that reason is not prominent with us. When we write a prescription for a mixture containing essence of pepsin and do not specify whose product should be used, have we any cause for anger when we find the dispenser did not put in Fairchild's? Or if we wish Squibbs' Ergot, yet do not say so, who's to blame when we don't get Squibbs? Should we call for Wyeth's Glycerophosphates, Sharp and Dohmes' Fluid Extract of Digitalis, a Parke, Davis & Co. tablet or pill, a Merrell product or a Nelson and Baker specialty and should we receive a substitute, we then have just cause for complaint, for this would be contrary to common honesty.

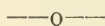
Now as to counter prescribing. Hundreds of doctors dispense their medicines not because they believe that to be the best method, but because they think the druggist does not give them a square deal if they use the prescription method. Many of these doctors will ask you "why should they send business to the druggist when he is continually taking business out of their hands by usurping the function of the doctor and prescribing for patients across the counter." And do the druggists do this? The strictly honest and honorable ones do not if they have paused to consider the subject properly. But many, many druggists do follow this course daily and seem to think they are doing no wrong. Some of our drug men in talking on this subject, will make light of the counter prescribing evil and maintain that it does not exist except in a very mild form. Perhaps an example or two will help to show that we really have cause for complaint along this line.

I happened to be in a drug store one day when the head clerk was out. A man came in and when the proprietor rose to wait on him he asked for the clerk by name. When told that the clerk was out the customer said he would be back again for "Mr. Clerk" had

been "fixing up" some medicine for him for the treatment of a personal ailment and he wanted to get some more medicine.

A physician of a neighboring town told me of a very flagrant case of this type. One day a man entered the doctor's office and stated that he wished to be treated for a disease which had bothered him for some time. The doctor asked why he hadn't come in for treatment sooner. We can imagine something of the doctor's feelings when the patient answered that he had first gone to a druggist, whose name he mentioned, and that the druggist had agreed to cure him for (\$10.00) ten dollars. He had taken the medicine furnished him for a couple of weeks, and getting no better, had told the druggist that he was going to quit and go to Dr. Blank—the doctor whose office he was then visiting. "Why," said the druggist, "you've been taking one of his prescriptions I have on file all the time."

This last case is an extreme one—the other illustrations more common—yet they go to show that both professions have their troubles. Harmony will benefit all of us but can only be attained by united action. We should each strive to give the other a "square deal."



Grocco's Triangle in Exudative Pleurisy.—Padoa (Gaz. d. Osped., 1907, No. 33)—It will be remembered that in 1902 Grocco and, somewhat later, Koranyi called attention to a triangular area of dulness occurring in cases of pleuritic effusion, along the spinal column on the healthy side. The most rational explanation of this phenomenon consists in the assumption that the effusion pushes the mediastinum away so that it comes, at least in part, to lie on the other side of the spinal column. Clinicians who claim to have observed this sign in pneumonia were apparently led astray by a simultaneous but overlooked pleuritic effusion. Interesting observations have been made in double pleurisies in which Grocco's Triangle shifts from one side to the other in proportion as one or the other effusion attains the higher level.



The only evidence of an acute intussusception may be the passage of a small amount of blood per rectum. One should always make a thorough rectal examination as even an intussusception high up in the small intestine may sometimes be felt per rectum.

SOME TRUTHS IN REGARD TO MEDICAL FEES.

By JOHN J. SIPPY, M. D.

The question of fees, in this age of labor unions, is indeed a popular and vital one. Each class and each section is a law unto itself, and its difficulties can be adjusted by no other class or section. Consequently, I have in mind only our local troubles, and shall discuss matters as I believe they exist at present in the jurisdiction of this society.

Probably there is no better paying class of people anywhere in the United States than Sumner county possesses—I mean as an average class—and no class more able to pay good average physician fees. And furthermore, I doubt that if anywhere in the United States physician's fees are lower. Possibly this is paradoxical, i. e., where one collects all his fees, he can afford to make them smaller than where he only collects one-half of them. I am also willing to admit that climatic conditions, and roads are as a rule of the best, and what fees we do get are, in that light, more easily earned than those practitioners receive in eastern states. But granting these facts, I still contend that under industrial conditions, the physicians of Sumner county are as a class very poorly paid. To fix responsibility for this state of affairs is not an easy matter. We cannot very well blame the older practitioner, for in his day the present schedule was amply adequate, and represented a fair understanding between himself and his clientele. Besides, under old financial conditions the smaller his fee, the less he was out by not collecting it. Custom—always difficult to remodel—has made us a legacy of this schedule, and whereas all other classes of labor have increased their wages from 50 to 200 per cent, we physicians are receiving the same old fees of a quarter of a century ago. Competition draws the lines closer, limits each field to a smaller territory, and demands a far higher grade of labor and equipment for even the same recompense, so that in a sense fees are even lower than they were twenty-five years past. A want of a common understanding on this subject among the members of the profession has not bettered matters any, and beyond the few ethics which govern an occasional consultation, each practitioner has been an isolated professional government in himself, his only law being a tacit or

implied acceptance of his charges as reasonable by his patients, a belief in "the survival of the fittest," and having little or no regard for either the welfare or embarrassment of any other physician. This feudal state is peculiar to the practice of medicine, where the personality of a man is his stock in trade, and where people demand this personality at any price, regardless of the service rendered.

A man may become grasping and avaricious, remarks the Chicago Clinic, even in the pursuit of knowledge; but when that avarice begins to work destruction to others, he becomes a menace to the general weal, however virtuous his quest. No individual in the medical profession has the right to pursue any course for his own benefit which is carried on at the expense of others and without their consent. Consequently in this matter of fees, as in all other matters, it is not a question of what this or that man may wish to do to conserve his own interests; but instead, one in which it is to be decided whether or not his actions are detrimental to the welfare of all other individuals of his class, and the subsequent conformance of his future acts to the decision of the majority of that class. Gentlemen, this may smack of the words of Gompers and Mitchell, but you must admit it is the foundation of all good government, and until all members of medical societies shall recognize and accept it as a first principle, just so long shall medical organizations remain so in name only. And just as long as we have individuals in our midst who refuse to accord with and recognize the rights of the many, and by underbidding in fees, or other acts, degrade the practice of medicine to a commercial basis in which those of us who must depend upon it entirely as a means of living, cannot afford to compete—just so long is our medical fraternity a large, huge joke, and those who labor for it had better rest from their labors and conserve their energies for worthier cause.

I say we can scarcely blame the older practitioners for the present state of affairs; but after all, is he not to blame? When he has watched the wages of farm hands increase from 50 cents to \$3.00 per day with board; those of a carpenter from \$1.25 to \$3.00 per day, those of a brick mason from \$2.00 to \$8.00 and \$10.00 per day of only eight hours; a teamster from \$2 to \$4 and \$5 and all other trades in proportion; the other professions demanding and receiving greater and greater rewards, the extravagance of the public in every other direction; the cost of his own living higher and higher each day; who in the face of all these facts, could be more justified in raising his own fees in proportion? If custom—

that oft quoted, choleric old dame—can exercise so much lenient expansion in favor of the farm hand, the carpenter, the brick mason, and teamster, what is to prevent her reconciliation to a higher scale for the physician as well, and who but himself will look after the doctor's dues? Besides, when he has acquired that experience which only toil and exposure, and years of study can bring, and which demand, and to which the public universally concede greater worth, the older practitioner should demand more money, fewer patients—and by that I mean fewer minor cases and more major ones—with shorter laboring hours, and more time for rest and recreation. It is his right and due, and consequently instead of reducing these fees to meet the rates of competing younger men, a transaction which flavors of his own inferiority, he should constantly maintain these rights. If he does not, he injures not only himself but the younger man as well, whom the public recognize as inferior and demand his acceptance of a fee in proportion.

Mr. President, I have heard it remarked by men outside the county, that in medical circles Sumner county has no dominant men, but that is a statement wholly untrue. It has dominant men—successful men—men to whose worth and medical opinion we all concede the greatest admiration—whose place in public opinion we envy, and have an ambition to equal—and whose services could demand and receive double and treble the fees of the average man; but if one were obliged to select these men by an inspection of the fee books in this county it would be impossible to do so. Not only that, Mr. President, but if they will pardon the personality of the allusion, some of these gentlemen I have just mentioned, whom I hold in the highest respect, and who, I believe, should be foremost in this contention for higher fees, at a meeting of this society not long ago, dissented and remonstrated against a majority vote adopting the \$5 insurance fee, and instructing our delegate to the state meeting to vote for it—a measure which was manifestly just, and of which the insurance companies were forced to take cognizance within a remarkably short space of time, thanks to united medical action elsewhere, if not here. I do not say that they were not conscientious in their remonstrance, and I mention it without any disparagement, and while in itself the incident was a trivial one and not worthy of further discussion, yet it is deplorable to believe that, in the face of present conditions, any attempt to improve them should have met with opposition from a single member.

There are several factors which have not been mentioned this evening, which might very properly receive some attention, and

which I will mention merely to bring them to your notice. One which I believe contributes as much to the debasing of the medical fee, as any other, a custom universal in this county, is that of dispensing. Were we pharmacists with no other occupation or ambition to do aught else I have no doubt that it would be profitable, but as a physician I do not find it so. For want of time I am driven to resort to formulary preparations, sold under trade names and as a consequence expensive. Often unpaid for by my patients, they barely return their own cost, instead of profit as is argued by some, and if I get economical and buy cheaper preparations I get no results, or harmful results. When stock runs low and a formula is exhausted at a time when I wish to prescribe it, it is difficult or impossible to duplicate it in taste, and other characteristics, and patients often lose confidence through a change in a remedy, which they are often convinced is exactly suitable to their requirements. And again you must admit that the method of using these formulae, which doubtless you all do, is not scientific, nor conducive to the welfare of a patient who is often doped with useless drugs, merely because it is impossible to eliminate them from a formula whose active principle you desire to prescribe. But overlooking these objections, and I might mention a hundred more, the principal objection in line with the subject under discussion, is the commercial one. First, the patient is prone to measure your service by the size of the bottle issued to him. Secondly, he always goes to the man who furnishes the largest supply of medicine, and Thirdly, he expects you to furnish medicine when he consults you, otherwise he expects the service to be free, and soon he regards you as a mere dispenser of drugs and on a par with the druggist who advises bromo-quinine for a cold. I overheard a conversation in which one lady remonstrated with another for paying a dollar for a patent preparation. "Why," she said "you could consult Dr. — (mentioning a man in a neighboring town) and get his advice and three bottles as big as that for 45 cents." How shall we remedy this? I do not know. Were all pharmacists honest it were an easy task. I believe the majority of them are, and it is too bad that a few that are not so should discredit the balance. Eliminating them, we should arrive at a fair office prescription fee, the selling price of the drug should be added to this, and we should constantly remember that our main earning is in the prescription fee, and not in the profit on the medicine. Anyhow we should do something to educate our people that we are physicians, and not drug clerks. And this education is absolutely necessary before we

can lend or add any dignity to the medical service itself. So often it is that the diagnostician goes unrewarded while the surgeon reaps the fee, and it is to this lack of education that this fact is due. For surgery is tangible, for at least the patient has a scar to show for his money, whereas the mind which detected the fault and directed the treatment by operation is forgotten with the anaesthetic.

Another item which needs correction is that of mileage, or rather it is one which should be more literally followed. All competition should be from a scientific standpoint alone. That is, if one of my competitors triumph over me through skill alone, all right and good—that is healthful competition which stimulates me to study more and to perfect myself to become his equal and his superior, a fact which adds to the welfare of my clientele. But when he invades my territory by underbidding me in fees, or by a wrongful interpretation in distance or mileage, he only drives me to protect myself by meeting his cut, while I feeling that I am already giving my patient more than his due am still more inclined to shirk my task, a fact which disparages the whole profession. That some of us are guilty of this practice, no one can deny, and though it is neither thou nor I, but the other man, it is up to us to see that he ceases the habit, and incidentally to prop up our own by doing so.

There are various others which might be mentioned but it would only be a repetition of facts, and to no purpose, I think we all agree that our services are not fully compensated, and that fees are low and should be raised, but who intends to set the pace. To do so by especial agreement is, as we all know, in direct violation of the Kansas law, and for one or two to attempt a crusade of general education of the public at the expense of their own practices and for the benefit of the apathetic remainder who have not the backbone to follow suit is a procedure which is hardly to be thought of. So how shall we arrive at a scale of fair fees and by fair fees, I mean those which represent justice to both physician and patient. If you will permit a suggestion, and in fact I should be willing to make it a motion in either regular, or in an informal meeting, that the chairman of the meeting shall appoint a committee of three members, who shall meet and prepare a scale representing a fair average minimum fee commensurate for each service rendered by the physicians of Sumner county; that a copy of this scale shall be sent to each member of this society at least ten days previous to our next regular meeting, and that action on same shall be deferred to our next regular meeting. Each member may

then, after careful study, make his own revision, and file his objections. I say that it is only necessary to agree upon the minimum fee, for I realize the necessity of an elastic scale that can be used with discrimination between rich and poor, but where conditions are so nearly equal as in Sumner county, it does not seem so impossible to arrive at a common and agreeable understanding to all concerned. In no other way can we arrive at this understanding, and whether we take any action or not it will at least be a step for the common good, which will prevent us from deteriorating.

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ROBBER FEES.

By W. H. NEEL, Jr., M. D., Anson, Kans., Sept. 21, 1907.

What is the significance of the caption "Robber Fees" as applied to the physician?

My idea of a robber fee is a fee so small that no physician with ordinary practice and ordinary environments can possibly maintain an existence.

Let me illustrate: I recently attended the family of a well-to-do farmer, and charged him the customary fee, fifty cents per mile and one dollar extra. He paid my bill without hesitation or ill feeling, as his previous family physician had been accustomed to charge him likewise. In course of conversation, though, he told me of the cheapest doctoring (as he expressed it) he had ever had done in Kansas. "One night I got sick, my doctor, Dr. A., was out of town; so I called Dr. B., a physician in the same town. Dr. A. had always charged me six dollars and fifty cents, as the distance was eleven miles. But Dr. B. only charged me three dollars and fifty cents, and said it would not have been so much but he just had to hire a horse." Strange to say, Dr. A. continued as the family physician; and Dr. B., to my knowledge, was never called again, as he had expected to be.

A physician moving into a new community announced that he would attend the first twelve cases of confinement for five dollars

Read before the Sumner County Medical Society Sept. 26, 1907.

each; and would make no charges for office practice to exceed the actual cost of the medicine.

Many of the older gentlemen present, have no doubt had more striking instances; but these two incidents have come under my own observation, and illustrate to an exaggerated degree what is meant by robber fees.

The cost of living, and of education, together with nearly every thing else, have made heavy advances in recent years; but the physicians' fees have remained unchanged for perhaps three-quarters of a century. Seventy-five years ago medical science was much more limited than the present time; and the dollar counted for a great deal more than now.

Compare if you please, physicians' knowledge then, with that of the modern and "up to date" practitioner. The former knew nothing of antitoxine; seldom quarantined against infectious diseases; did not know of appendicitis; could not positively differentiate typhoid and malarial fever; had never seen a curett did not know the gall bladder was subject to infection; only the most skilled surgeons would perform a tracheotomy; but few general practitioners used obstetrical forceps; seldom repaired a lacerated cervix or perineum; did not know that asepsis ever would or could exist. Surely the physician who is well informed on these subjects and can do these operations, when necessity demands, ought to be worth more in dollars and cents to his patrons, than the physician who was in the earlier years ignorant of them.

How about the comparison in standards of education? The early practitioners, had for the most part, a very limited common school education; they spent two terms of five months each, at the medical college, and were then privileged to practice. How different in the case of the modern graduates in medicine of today; they have for the most part secured a college education (and this demand for a college education before entering the medical colleges of our land will become more and more essential as time goes on); they must spend from four to six years in the medical colleges; and many have held an internship in some hospital.

Now that the condition of ridiculously low fees does exist in so many communities, who is responsible? Surely not the people. No. It is the physician himself. Both veterans and young practitioners are responsible. I have heard some one say, "Certainly when the older men are willing, the younger ones ought not be bashful." I am sorry that this state of robber fees does exist, but it's a fact; a deplorable fact, that we have in our profession, men

who will, through lack of self esteem and loyalty to the profession, stigmatize it and lower its dignity, by placing a valuation upon their services, which is on a par with the common day laborer.

The community surely values a physician according as he places a true valuation upon his ability and services. True, his fees have to be governed to some extent by the local commercial conditions. But if every practitioner in a given community would charge what he conscientiously knows to be just, instead of deducting 20, 30 or perhaps 50 per cent, as some do in order (as they think) to retain the patient's patronage; there would be but little room for complaint.

I would not have you believe, gentlemen, that I favor extortion. Far from it. I believe that we as physicians, must be generous with our knowledge and skill; even to the rendering of gratuitous services, when the circumstances of the individual seem to demand it. Who is there of us who has not gone into hut and hovel, at the midnight hour (when sleep and rest were greatly needed) and with willing hands administered to the sick and suffering, well knowing that we would not receive one penny as compensation? Who is there among us, who does not consider well a patron's financial condition, before making our charges, especially for surgical and consultation practice? This I regard as being equitable and just; but the physician who will make a small charge to the man who is well able to pay for the services, simply with a view of retaining his patronage, is a disgrace to our most noble profession and a menace to its progress.

Gentlemen, before making your charges, I ask you to consider well these facts; you are expected to be proficient in your line of work; to be modern in equipments; to treat a great many deserving poor gratuitously; to contribute as largely as any other individual in the community for benevolent purposes; to educate your children, both in letters and in art, and keep them in the highest social circles. Then too, you must have time for study and recreation; and really should take post-graduate work every few years. If you are not able to give your patient every advantage for his life, known to modern medicine and practice; then you are not worthy to be called into the sick chamber. In other words you are expected to keep up to date by study and post-graduate work; so as to give the patient advantage of every possible factor which may add to his recovery.

All this costs you dollars; dollars that are hard earned; dollars that are frequently difficult to get.

If you feel that your services are not worth as much as those of your competitor, wipe the dust from off your text books; read up; take a post-graduate course; make yourself worthy the honor conferred upon you by your alma mater; as well as worthy of the confidence imposed within you by your patrons. If you are not a help to the profession, get out. Don't be a "hanger on." Push, and do everything you can for the advancement of your high and noble calling to its highest possibilities.

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NIGHT FEES

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By G. R. WAITE.

This is a subject which has been on my mind for some time, especially about the time I get a call from one to three hours after going to bed, with the expectation of getting a good night's rest, and then the night is just as liable to be the worst of the year, with rain or snow falling, such as one night I remember last winter, when I had to unhitch and pull the buggy out of a snowdrift with the lines tied to tugs and holdbacks, a pleasant experience, I assure you, to take place about 11 p. m., and all alone at the time. When arriving at your destination, you will in nine cases out of ten, find a patient who has been sick from ten to twenty-four hours, but have put off sending for you, in hopes that they would get better by taking a dose or two of Baker's Liniment, thereby saving a doctor's fee, another thing which makes you feel good. This will happen time and again, with all the talking you may do in regard to sending for you in the day time, they will persist in waiting until after dark.

Getting up from a warm bed and out of a sound sleep, is not a pleasant experience at any time, especially on a cold night, it is very exasperating to a man's inner feeling as well as trying to his physical being. To lose the greater part of a night's rest incapacitates one for the next day's work, to the extent that you take no interest in your practice, and would rather not see a patient enter your office than to be bothered waiting on them. It not only short-

ens a mans' earthly existence by taking him from his natural resting place and keeping him at work when he ought to be asleep; but there is another side which we should consider; according to an article published in the American Review of Reviews, some few months ago, a table was given showing the advance in the prices of commodities which has taken place in the last ten years. There was a gradual decline in the prices of all articles whether useful or ornamental, from about 1889 until the year 1896, when they reached rock bottom, and people had no money with which to buy them, at any price. But following that year times have changed, prices have steadily advanced, until today we are paying from 10 to 20 per cent more for all articles than was ever known in the history of this country since war times. On the other hand, the people are in much better condition to pay the higher prices now, than they were the low prices of ten years ago. The only scarce article of trade today is labor, which can demand almost any price and can come very near getting it; but have the doctors raised the prices for their night labor? I think not, but realize that it is about time they were doing so, and suggest to the members of this society, that we make a uniform charge in this county, of an advance of 50 per cent for a night call over the prices charged for the same call made during the day time, which will materially help out, not only in a financial way, but will have a tendency to make our patients call us before the sun goes down at night or after it has risen in the morning, so that we may get our required amount of sleep and live out our natural lives to enjoy the hard earned money, in seeking rest and recreation when our usefulness has ceased to be a source of income.

THE JOURNAL OF THE KANSAS MEDICAL SOCIETY.

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CHAS. S. HUFFMAN, EDITOR

J. E. SAWTELL, {
GEO. H. HOXIE, } ASSOCIATE EDITORS

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The Care of The Insane.—The Journal has reiterated several times its belief that the state should try to cure the insane, not merely care for them. We, therefore, note with pleasure, the following dispatch printed in the Kansas City Times of October 10, 1907. We would, however, like to call attention to an inconsistency in Mr. Elliott's position. It is this: If insanity is to be treated early enough to effect a cure, someone must take a very early diagnosis. Practically the only medical man who sees insanity in its earliest stages is the family physician—the general practitioner. Now, the majority of the physicians now practicing in Kansas did not see twenty cases of insanity (if they saw any at all to recognize them) during their student days. How then could they recognize incipient cases—the very kind that is most difficult to recognize? Mr. Elliott wishes to exclude medical students from the state hospitals. He would deprive the Kansas Medical College of the use of the Topeka hospital, as well as the state school from that and any others. Where, then, are the physicians of Kansas—the majority of whom are educated in Topeka and Kansas City—to secure their training in recognizing and treating insanity?

Would it not be well for our county societies to interest themselves in the matter and secure for our two medical schools a better course in psychiatry?

Here is the clipping:

Toepka, Oct. 9.—Sherman Elliott, member of the state board of control, who visited many of the important hospitals for insane in the East last summer, advocates the installation of reception hospitals where the water cure or electric treatment may be given to those suffering from the first attacks of insanity. These suggestions were made in a report to the governor. Mr. Elliott has gathered much information which he believes substantiates his contention that many patients admitted to the hospitals could be cured if the proper treatment were given when the patient showed the first signs of insanity. About one-half of the insane patients who re-

cover at all, recover in the first six months. Cases of a patient recovering a year later than the first attack are rare, but in many instances where "intense" treatment is given at once the physicians are able to work a cure.

Mr. Elliott advises against allowing the medical students of state schools to conduct experiments with the patients under state care. He does not want any provision made for annexing medical schools to the state hospitals. He also asks the governor to commend a hospital for the criminal insane, so that they may be confined separately from sane prisoners and from other insane patients.

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Baltimore, October, 1907.

Dear Sir:—At the recent annual meeting of the American Pharmaceutical Association the undersigned was directed to send you a copy of the following resolutions:

Whereas; The American Medical Association, the American Pharmaceutical Association and the National Association of Retail Druggists together with many state and local organizations and journals in both professions have been for some years endeavoring to bring about a return to the practice of medicine based on the Pharmacopoeia, and

Whereas; The medical colleges are represented on the Committee of Revision of the U. S. Pharmacopoeia, and

Whereas; It is manifest to the thoughtful men both in medicine and pharmacy that a very large number of medical men might be better informed regarding the Pharmacopoeia, a book of reference and standards. Be it therefore

Resolved: That it is the sense of the American Pharmaceutical Association in convention assembled, that a great advance in the ethical practice of medicine and pharmacy will be made when the medical colleges make the Pharmacopoeia a prescribed text book or book of reference and require a familiarity with it in their examinations.

Resolved: That we request the governing authorities of all medical colleges in the United States to put into force such a ruling in their respective institutions as will insure in future classes a well grounded knowledge of materia medica and Pharmacognosy, as set forth in the Pharmacopoeia.

Resolved: That the general secretary be directed to transmit a copy of these resolutions to each medical college in the United States and to the medical and pharmaceutical press.

Yours very truly, CHAS. CASPARI, JR., General Secretary.

ABSTRACTS.

REPORT ON THE PRODUCTS OF THE REED & CARNRICK CO.

A report of the Council on Pharmacy and Chemistry of the American Medical Association on certain widely advertised preparations of the Reed & Carnrick Company is published in the Journal A. M. A., October 5. The council found the claims of the manufacturers grossly exaggerated, unwarranted and misleading. These products, peptenzyme, protonuclein, nephitin and trophonine, all appear to be based on a theory which, though vaguely stated and not readily intelligible from the literature sent out, seems to be, in substance, that certain of the constituents of practically all animal cells possess properties of great therapeutic value, acting specifically on the organs from which they are derived. These properties are claimed to be distinct from those hitherto associated with internal secretions these constituents being at once directly assimilated by the cells, without change, and at the same time acting as stimulants to the cells. They are said to reside exclusively in the unaltered nucleoproteids and nucleo-albumins of the living cells, which act as ferment, and are hence given the new name of "nucleo enzymes." These properties are destroyed by a temperature above 40 C., and by the action of even the mildest reagents, but can be preserved by drying at temperatures below that limit or by extraction with glycerin. These Reed & Carnrick preparations are claimed to be thus prepared and to differ from all other animal extracts or preparations. These claims are taken up and critically analyzed. Among the claims rejected as absurd are: 1. That these dried cells and glycerin extracts represent living protoplasm; 2. that they can pass unaltered through the digestive tract and be assimilated directly by the body cells in spite of the profound chemical and other changes that they must undergo, and the further fact that if they could thus pass the digestive ordeal, they, being derived from the lower animals, could not supply the body cells with their own specific substance, and would, therefore, be as much more likely to be toxic as nutrient. There is no evidence that such "nucleo-enzymes" can pass the ordeal of digestion or that they actually exist in these dried cells and extracts, and there is, moreover, no instance known of a ferment entering into a cell from without. Trophonine and protonuclein, of the above named several products, were investigated independently by two members of the council, but as the conclusions agreed, only one of the two reports is embodied in the council's report. The examination seems to have been thorough

and the details are interesting. As regards nephritin the information received was too meager to permit its admission. Both this preparation and protonuclein may be re-submitted to the council when the manufacturers are prepared to present only demonstrated facts and full information. Peptenzyme is also rejected, the statements as to its virtues being considered entirely unwarranted. In conclusion the council's report says: "The Reed & Carnrick Company pretends to have discovered a new method of cellular therapeutics, based on the advanced research of eminent independent investigators in physiologic chemistry, supplemented by the work of Reed & Carnrick's laboratories. A critical analysis of these pretended discoveries shows that they consist of a tissue of vague speculations, which are not deducible from the researches which are quoted in their support, but that, on the contrary, they are in direct conflict with the known facts of physiologic chemistry. No facts are adduced in support of these speculations, or to explain the contradictions. Since the claims of superiority and novelty are based mainly, if not entirely, on these speculations, the council has not taken up the question of their clinical results. These could hardly be used as the basis of a theory of this kind. However, so far as one can judge from the reports adduced by Reed & Carnrick, these clinical results are in no way remarkable for their novelty."

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Chicago, July 9, 1907.

Dr. Philip Mills Jones, San Francisco, Cal.

Dear Doctor Jones:—Some time ago you wrote asking that we give you some reasons as to why the state journals and, in fact, all journals ought to supply the council on pharmacy and chemistry, and refuse to advertise any proprietary medicines that have not been passed on and approved by the council.

The council is purely a voluntary organization, and the result of its work will depend on its endorsement by the medical profession of the country. There is no law of any kind to compel manufacturers to submit their preparations, unless it be the moral law or influence of the medical profession.

Already a large number of manufacturers have earnestly cooperated by submitting their preparations and have heartily assisted the council, because they believe that the ultimate results would be for the best interests of the honest manufacturers. Some of these manufacturers undoubtedly submitted their preparations because they thought it was policy to do so and because they believed

that the medical profession would back up the council. A large number of manufacturers have held back from the beginning and have done all they could to counteract the influence of the council.

Now one thing is sure to result: if the medical profession and the leading medical journals do not endorse the council, not only will those who have been opposing the council and refusing to come in continue in this, but any of those who have already submitted their preparations and who are now conforming to the requirements of the council, will regret their action and go back into the old way.

Already about six hundred preparations have been considered by the council and nearly three hundred have been approved. This shows the progress that has already been made. In the early work of the council, matters went very slowly for various reasons. Now, however, the council is prepared to act promptly on all articles submitted unless the statements made for the product require verification. While a considerable number of products are being submitted to the council, mostly, however, of a poor kind, yet it is evident that many firms are awaiting to see what the profession is going to do about it. If, just at this time, it is made evident to them that the profession is earnest in backing up the work of the council, these firms, and among them are the largest in the country, will promptly submit their products for approval.

For years, as you know, it has been recognized that the proprietary medicine evil was a vicious one, and that many of the preparations were fraudulent or advertised in a most deceptive manner. There has been no way for the profession to distinguish between the good and the bad—in fact, it is utterly impossible for the physician himself to look into this question, for it is one that relates to pharmacy, chemistry and pharmacology each equally.

The council went at the matter deliberately and adopted certain rules or principles on which to work. These rules as you know simply require that the product shall be honestly made; that the profession shall not be exploited as agents to introduce these medicines to the public.

The council accepts all articles submitted which comply with the rules. In case they do not comply the manufacturer is advised of the conflict and given an opportunity to eliminate objectionable features if they are of such character that they can be eliminated.

While the profession has accepted the findings of the council so far as the rank frauds exposed in the Journal are concerned, some physicians have been uncertain in regard to their attitude toward those products which, without having been branded as frauds, yet are

not listed with the "approved" articles.

In regard to this, it should be emphasized that it will not do for any individual to use his own judgment in individual cases, for if he does it will show that he lacks confidence in the council. And if the individual lacks confidence, then the profession as a whole may be expected to lack confidence. Unless there is some good reason for believing that the council is not just, fair and equitable to all, its conclusions should be accepted.

The state journals must be the first to set the example by refusing to accept an advertisement of any proprietary medicine that has not been approved. If all the state journals will do this heartily, the battle will have been won within one year, for these journals wield an immense influence. Undoubtedly, it will be at a loss of advertising patronage, and thus at a sacrifice, but I believe that in time the loss will be very small.

One thing is certain and cannot be too strongly emphasized, and that is, if the state journals do not endorse the council in this effective manner, the privately owned journals will have a good excuse for not doing so.

Very truly yours,

(Signed) GEORGE H. SIMMONS.

The Doctor vs. the Nostrum — Will You Help?

THE YEAR'S FIGHT

Having the insurance fight won, excepting only as against the New York Life, which is practically out of business in the state, our best energies as individuals and as an organization are to be devoted this year, by direction of the house of delegates, to securing pure drugs and to ridding ourselves of nostrums. The resolutions published herewith are direct and to the point. No doubt is left as to their meaning. It is particularly urged that you refuse to receive from the postoffice copies of trade journals. Many of the great pharmaceutical houses get out such sheets and send them to physicians, hoping to lure them into the use of their specialties. Most of these specialties, and all such so-called journals are conceived in fraud and brought forth in iniquity. Refuse to accept them and thus help to kill them.

Next, look through the pages of every medical journal to which you subscribe, whether it belongs to a state or other organization, or is supported by the members of the National Proprietary Association, the patent medicine vendors' collusive family, or what not, and if you find the nauseating advertisements of the blatant frauds

already exposed by the council on pharmacy and chemistry, write a personal letter to the editor, the publisher and each collaborator, calling their attention to such frauds. Do not talk about it! Write, and write today, and help to save our honorable profession from the vampires who exploit it, to its own shame and dishonor.

In addition to this we have arranged with the American Medical Association to keep a supply of the Manual of the Pharmacopeia and the National Formulary, recently prepared by Mr. Hallberg, on hand in our Journal office. Send 50 cents in money or stamps, and by return mail we will send you not only this valuable book, but also the latest revision of the list of new and non-official remedies approved by the council on pharmacy and chemistry of the American Medical Association. In one of these two books will be found every medical agent necessary to any intelligent doctor. As suggested by one member at this meeting, let each of us get these little books and learn the honest remedies, that it may not be necessary to rely on the nostrums, and our own ignorance.

Read these resolutions carefully, and, by the same concert of action as won the insurance fight, do your best share toward winning this one. "United we stand, divided we fall!"

COMMITTEE ON PHARMACOLOGY.

Whereas, the American Medical association has established a council on pharmacy and chemistry, composed of scientists of world wide reputation and standing, whose function is to examine pharmaceutical products in order to be able to inform the profession as to the actual composition of said products, and,

Whereas, after careful examination of many hundreds of said products, it has officially announced its approval of a large number of them, and, in order to make clear to the profession the methods and purposes of their work, have published exposures of a large number of the fraudulent preparations that have been foisted on the members of the profession and, through them, on the public by interested owners and manufacturers, frequently laymen, ignorant of the use of drugs, except their meretricious use as examples of the much larger number which they have found of little or no value or positively harmful, and,

Whereas we believe that every physician in Kentucky is vitally interested in the work of this council and desires in every possible way to promote its usefulness and interest, and,

Whereas, the greatest aid to the nostrum manufacturers in their nefarious and avaricious work has been the medical press, whether

controlled by medical organizations, individual members of the profession or interested lay-firms, and,

Whereas, we believe the time has arrived when the great profession of medicine, and all agencies controlled by it should divorce itself permanently, finally and forever from those interests which, like ghouls, prey upon the sick and afflicted through the commercial sale of nostrums and dishonest, so-called proprietary medicines, now, therefore, be it

Resolved, by the Kentucky State Medical association, in annual session assembled, that we heartily endorse the formation of the council on pharmacy and chemistry, that we extend it our confidence and congratulations on the splendid work already accomplished, and that we pledge it our unanimous support in its purpose of freeing our profession and its publications from nostrum control and be it further

Resolved, that, in pursuance of this object, we request each county society in Kentucky to devote a special session to consideration of this important question with a view to securing the active aid of every licensed practitioner in the state, and that the council of this association be requested to omit from the advertising columns of our Journal all pharmaceutical preparations which are not manufactured in conformity with the U. S. pharmacopea or the National Formulary until they have been approved by the council on pharmacy and chemistry of the American Medical Association; and, be it further

Resolved, that we request every physician in Kentucky to secure a copy of the abridged U. S. Pharmacopea and Formulary and be guided by this and the approval of the council on pharmacy in their use of medicines; and, be it further

Resolved, that our council be directed to communicate with the editors, owners, collaborators and publishers of the medical journals of this country on this subject, and to announce to the profession of Kentucky through the columns of our Journal such publications as are willing to assist the profession by freeing their columns of nostrum advertising, and we hereby pledge our support to such journals even if they find it necessary to increase their subscription rate, and further, be it

Resolved, that we expressly condemn the publication of so-called medical journals by interested manufacturers of nostrums, and request the profession of the state to decline to receive them.

SOCIETY NOTES.

The regular quarterly meeting of the Western Kansas Medical Society was held at Oakley, Kan., October 9.

The meeting was called to order at 10:30 a. m. by President V. C. Eddy. The following members responded to roll call: Drs. Eddy, Stoner, Lewis, Stroup, Miller, McNaughton, Blake, Parker, Gillam, Carmichael. Visitors, Dr. Findlay of Hill City.

After the usual routine of business the regular program was carried out. Drs. Beckner and Howell being absent their papers were not presented. Dr. Blake of Ellis, presented a case report of labor and its puerperium, embracing among many other interesting features, complete inversion of the uterus with the occurrence of a typical malarial cycle initiated on the 21st day of the puerperium. The case presented many obscure phenomena and was discussed at length and with great interest.

Dr. J. H. McNaughton, gave a short dissertation on cholera infantum with especial reference to its treatment which was generally discussed.

Dr. Carmichael presented a short paper on Medical Organization, which was very kindly received.

Dr. Miller presented a paper on Heart Lesions of Infancy and Childhood, that was of exceptional merit. The president then appointed a committee of two, consisting of Dr. Carmichael and Dr. Stoner, to draft resolutions endorsing the enactment of pure food and drug laws similar to those adopted by the state of North Dakota, the efforts of the State Board of Health to secure financial aid for the maintainance of a state laboratory of Hygiene at Topeka, for the creation of a board of vital statistics, the enactment and enforcement of dairy and cold storage laws, state food inspection and such other measures as are calculated to safeguard public health and promote public sanitation.

The meeting adjourned to meet at Colby, Kas., the second Wednesday in January. This was the best attended and most interesting meeting ever held by this society and indicates the growing interest in the subject of medical organization in the eighth district.

F. A. Carmichael, Secretary.

Topeka, Kans., October 11, 1907.

Dr. Chas. Huffman, Columbus, Kans.

Dear Doctor:—The regular meeting of the Shawnee County So-

ciety was held October 7th. There was a good attendance, about 20 members being present.

Dr. J. E. Minney presented to the society a clinical case, a girl of 12 years; with a chronic otorrhoea of ten years duration and peculiar tumor growing in the middle ear. The case was a fine one for demonstration, and was examined and discussed at length. Operation with the removal of the tumor and other offending tissue was decided upon. The society then took up the X Ray in general practice. Its extreme value in locating foreign bodies in the eyeball and elsewhere was discussed, as was also the dangers to the operator from its action and the best means of protection. Nearly every member present voiced some decided views on this subject, and the topic proved both profitable and entertaining.

After some miscellaneous business the society adjourned.

J. B. TOWER, Secretary.

NORTHEAST KANSAS DISTRICT MEDICAL SOCIETY.

The regular semi-annual meeting of the Northeast Kansas District Medical Society was held in the Throop Hotel, Topeka, October 10th. About 60 physicians were in attendance, half of that number being from out of town. There were two sessions, afternoon and evening, with a supper provided by the local fraternity. Many excellent papers were read, and the best and most cordial spirit of fellowship prevailed.

Second Annual Meeting of Medical Association of the Southwest

The second annual meeting of the Medical Association of the Southwest met at Hot Springs, Ark., Oct. 8, closing the 10th., something over 100 active enthusiastic physicians and surgeons, with a goodly number of eye and ear men in attendance. The papers read were of an unusually high character and were all ordered published in the different state journals. Every session was one filled with earnest enthusiasm, and while the meeting might have been more largely attended, the quality of those attending made up for lack of numbers.

The first session was of the executive committee, which met in the Arlington Hotel at 10 a. m. on the morning of the 8th. After appointing a credential committee consisting of the Secretary-treasurer as ex-officio chairman, and Drs. M. F. Mount, J. R. Randolph and J. M. Proctor, and a committee to audit the report and books

of the secretary-treasurer, consisting of Drs. L. H. Buxton, Geo. M. Gray and T. E. Holland, the committee adjourned to give an opportunity for this work to be done, and to meet again at 1:30 p.m. at Eastman Hotel.

Promptly at 1:30 the committee met in the committee room at the Eastman Hotel, when the chairman of committee on arrangements, Dr. T. E. Holland, made a report of the plans for the meeting. As many of the members had not yet arrived it was decided to change the program as laid down, and after having the addresses of welcome and the responses, to adjourn to take up the scientific work in sections, and to defer the report of the committee and officers until a later session. The committee then adjourned to meet at the Arlington Hotel at 8 p. m. The evening session was dispensed with and the members allowed the evening for social purposes.

At 2:30 p. m. the general session of the association was called to order in the auditorium of the Hotel Eastman, by chairman of the committee on arrangement, Dr. T. E. Holland, Hot Springs, who introduced the mayor of the city, Hon. M. A. Jodd, who, in a short address, welcomed the visitors to the city. This was followed by Dr. O. H. Burton, who, in the name of the local medical society of Hot Springs, also welcomed the members of the association. Dr. Holland then called upon Dr. Bacon Saunders of Fort Worth, Texas to respond to these addresses in behalf of the association, saying at the same time that the governor of the state of Arkansas, who was expected to speak to us as the representative of the state of Arkansas had been suddenly called to his home in Little Rock on account of sickness, and would not be able to be present.

Dr. Holland then introduced the president of the association, Dr. Chas. M. Rosser, of Dallas, who in turn called upon Dr. Holland to make a brief statement of the plans for the meeting.

Dr. J. N. Jackson then moved, which motion was duly seconded and carried, that the state delegations meet at 8 p. m. in the Arlington Hotel to caucus for five members of the nominating committee, one member of the executive committee to serve three years, and one vice-president from each state.

Moved by Dr. Saunders, duly seconded and carried, that all physicians in attendance be granted the privileges of the floor.

Meeting then adjourned until Wednesday evening at 8 p. m.

Arlington Hotel, Oct. 8th, 8 p. m. Meeting of the executive committee called to order by Pres. Rosser with the following members present: C. M. Rosser, E. H. Carey, T. E. Holland and F. Vinsonhaler, A. L. Blesh, E. Meek, Geo. M. Gray, Bransford Lewis L. H. Buxton and F. H. Clark.

The secretary reported that an arrangement had been made with one Mr. Oliphant to report the proceedings of all sessions for consideration of ninety dollars which agreement was ratified and the secretary instructed to pay the bill.

The secretary then read some correspondence with the secretary of the A. M. A. and Dr. J. M. McCormack, relative to the constitution already adopted by the association, and the present status of the Medical Association of the Southwest as one of the branch associations of the A. M. A. and presented a copy of the constitution suggested by the committee on organization of the A. M. A. This was the subject of much discussion, and upon motion the whole matter was laid upon the table until a copy of the journal of the A. M. A. of June 15th could be secured for reference.

The secretary-treasurer now presented his report, which related that at the beginning of this meeting the association had 379 members in good standing who had paid their dues for the first year. He reported also that a copy of the constitution and by-laws adopted by the association had been forwarded to Dr. J. M. McCormack, by registered mail and his receipt received for the same, with a request that the same be carefully examined and the secretary be informed if there were any objectionable features in the same; but as response has never been received from the doctor, he had presumed that it was acceptable to him as the representative of the A. M. A.

The report shows that in compliance with the sentiment of the last executive committee meeting the secretary had, before planning for the present meeting, written to every member of the committee personally asking them for their vote as to whether we should have a two or a three days session, and that as the vote was almost evenly divided he had compromised by providing for a two and a half day's session.

The financial statement was as follows:

Balance on hand last report.....	\$156.11
Received from dues since then.....	444 00
Total.....	600.11

Disbursements as follows.

Stenographer, Hotel Lee.....	2 50
Badges Oklahoma City meeting.....	11.50
Banners at Hotel Lee.....	3.50
Miss Norton, stenographer.....	70.00
Printing bill.....	128.50
Assistance addressing envelopes.....	10 00
Rent of typewriter.....	25.00
Paid for typewriter table.....	4.00

Postage	177.60
Incidentals	5 62
Balance on hand	589.51
Unpaid Bills:	
Printing bill estimates	125.00
Stenographer	90.00

On motion duly seconded and carried, the above report was accepted, ordered filed, the bills allowed and paid.

On motion, duly seconded and carried, secretary-treasurer was authorized to secure such services from a stenographer as he needed to carry on the work and to pay for the same from general funds of the association.

Moved by Dr. Bransford Lewis, and seconded by Dr. Bacon Saunders, that the secretary read the names of all members who had joined the association since the last meeting, before the general session. Carried.

The auditing committee now reported that they had carefully examined all the books and records of the secretary, and, at his request, had extended their examination back to the time of the beginning of the association, as they were not audited last year; and had found the figures as given in his report exact and true. They further reported that the secretary-treasurer has made no charge for stenographer or for services in mailing over 16,000 circular letters besides carrying on a heavy correspondence incident to his office; for this large amount of labor of love for our association we believe that the gratitude of the association is due our able secretary-treasurer.

L. H. BUXTON,
GEO. M. GRAY,
T. E. HOLLAND,
Committee.

Dr. T. E. Holland now suggested that some plan be formulated that each county society be requested to send a representative to each annual meeting.

Dr. Lewis moved, which motion was seconded, that a committee consisting of Dr. Holland and two members appointed by the chairman, be appointed to devise means to carry out the idea suggested.

Dr. E. H. Carey made a substitute motion, that the vice presidents from each state be requested to carry out this work; substitute seconded by Dr. A. L. Blesh; after a considerable discussion the substitute was withdrawn.

Dr. Blesh now moved that the matter be laid on the table and

that the secretary-treasurer be instructed to work through the secretary of each county society. Motion not seconded.

Dr. Saunders moved as an amendment that all questions and suggestions regarding this matter be referred to the special committee who were requested to report at a later meeting of the executive committee. Motion carried as amended.

Chairman appointed Drs. T. E. Holland, F. Vinsonhaler and Bacon Saunders as this committee.

Committee now adjourned to meet at 5 p. m. Wednesday.

Hotel Eastman, October 9th, 5 p. m. Meeting of the executive committee called to order by Pres. C. M. Rosser; present Drs. A. L. Blesh, T. E. Holland, C. M. Rosser, E. H. Carey, F. Vinsonhaler, L. H. Buxton, Geo. M. Gray, C. E. Bowers and F. H. Clark.

On motion the committee on publication was granted further time.

After discussing the adoption of the constitution sent by the committee on organization of the A. M. A., motion was made, duly seconded and carried, that a committee consisting of the retiring president, president-elect, the secretary-treas., and one representative from each state act as a committee to attend the next meeting of the A. M. A. and confer with the house of delegates regarding the adoption of the constitution. Chairman appointed as such committee Drs. C. M. Rosser, T. E. Holland, F. H. Clark, Jabez N. Jackson, Bacon Saunders, Chas. E. Bowers, A. L. Blesh and R. Brunson.

On motion duly seconded and carried, the question of whether or not we shall meet in a general scientific session or in separate sectional meetings at the next annual meeting, was referred to the general session to be held on Thursday morning, October 10th, with the recommendation of the executive committee favoring the general session, the section officers to be elected the same as at present and the same to preside over the meetings while subjects and papers under their respective sections are being discussed.

On motion, duly seconded and carried, the secretary was instructed to have one thousand copies of the constitution printed.

On motion, duly seconded and carried, the secretary was instructed to prepare and present the report of the executive committee at the general session on Thursday a. m.

On motion, duly seconded and carried, the section officers-elect were instructed that in order for any name to appear on the program in the future, the paper must be in the hands of the general secretary of the association before the program was given to the publisher. Committee adjourned.

Auditorium, Hotel Eastman, October 9th, 8 p. m. General session of the association called by Pres. Chas. Rosser, who introduced Dr. Wm. G. Moore of St. Louis, Mo., who delivered the address of the evening, using as his subject "Above all the Clinician." Dr. Moore's address was of more than usual interest and was enthusiastically received by all present. At the close of the address the secretary made the announcements for the next day, and the session adjourned.

Hotel Eastman, October 10th, 10 a. m. General session of the association called to order by Vice Pres. John Punton; the president of the association then delivered his annual address, which, upon motion, was received, ordered published by the secretary and a copy mailed to every member.

The report of the executive committee was then presented by the secretary-treasurer. The report gave in detail the work of the association for the past year, showing the efforts made to bring the association to the attention of every practicing physician who was a member of the component state associations, and to adjust the matter of constitution between the house of delegates of the A. M. A. and the association and asked that its action in appointing a committee to confer with the committee on organization of the house of delegates of the A. M. A. at the next annual meeting, be approved by the general association.

Definite plans for the enlargement of the work through the county associations were also proposed; the report of the secretary-treasurer shows that at the beginning of this meeting there was on hand a balance of \$151.29, and that during the meeting a great many had paid dues, which would increase this balance materially.

The unpaid bills were as follows:

Ticket agent for validating certificates	\$23.00
Stenographer	25.00
Printing bill	125.00
R. J. Crabill, Secretary Tri State Assn.	54.50

The report also shows that at the beginning of this association there were 379 members in good standing and that during the meeting 45 new applications had been received, making a membership of 424 in all. This we believe, should be doubled before the close of the present year by a little effort on the part of each member.

The names of all members received since the last report are hereto attached and will be read at the close of this report.

Your committee have also carefully considered the advisability

of having more general sessions than have been held this year, and desire to have the sentiment of the association in this matter; we recommend that the section officers be retained as at present, but instead of each section meeting separately as at present, until such time as the association becomes much larger, we believe will be for the best interests of the association that the papers of each section be read before a meeting of all the members, the regular section officers of the section for which the paper was prepared presiding, and an opportunity given for all to take part in the discussion.

We ask the association to take such action as they may see fit regarding the above suggestion.

Respectfully submitted by order of the committee,

F. H. CLARK, Secretary-Treasurer.

Motion was made, duly seconded and carried, after a full and free discussion, that the report of the committee as read be adopted and the suggestions as read be authorized.

On motion the committee asked for, to meet the house of delegates of the A. M. A., was authorized. Motion seconded and carried.

Motion was made, duly seconded and carried, that the financial report as read be adopted and the bills be ordered paid.

Moved, seconded and carried, that the suggestion regarding the section on something in common be adopted.

Moved, seconded and carried that the secretary be instructed to add the names and address of all members to the constitution when it was printed.

The nominating committee now presented their report and suggested the names of Dr Jabez N. Jackson and T. E. Holland for president; the president appointed as tellers Dr. S. C. James, F. D. Boyd and L. H. Buxton, who collected the ballots, which showed that Dr. Jackson received 30 and Dr. Holland 39 votes.

Dr. Holland having received a majority of all the votes cast, was declared the president for the coming year.

The president appointed Dr. Jackson a committee of one to escort the newly elected president to the platform, where he thanked the association for the honor they had conferred, and asked for the hearty co-operation of every member in making this association of great usefulness to the physicians of the different states.

The nominating committee then recommended for vice-president for the coming year Drs. S. S. Glasscock of Kansas City, Kansas, S. C. James of Kansas City, Mo., J. E. Gilcrest of Gainesville, Tex., and B. J. Vance of Checotah, Okla. For secretary-treasurer,

Dr. F. H. Clark of El Reno, Okla.

On motion duly seconded and carried, the secretary was instructed to cast the ballot of the association for each of the above named officers. The secretary then cast 69 ballots for each officer named.

The nominating committee then presented the names of the following as members of the executive committee to serve three years: Dr. C. Travis Drennon of Hot Springs, Ark., Dr. W. G. Moore of St. Louis, Mo., Dr. L. H. Buxton of Oklahoma City, Okla., Dr. J. H. Johnson of Independence, Kan., and Dr. G. H. Moody of San Antonio, Tex.

On motion the secretary was instructed to cast the ballot of the association for each of the above named members; the secretary then cast 69 ballots for each officer named as directed.

The nominating committee then placed in nomination for the next place of meeting, Kansas City, Mo., which, upon motion, was unanimously selected.

Dr. Clark, who was elected as secretary, asked that he be excused from serving, because of the pressure of other duties; Dr. Bransford Lewis moved that in order to assist him in making the duty as light as possible the association authorize him to procure such assistance as he needed at the expense of the association, which, upon motion, was duly authorized.

On motion duly seconded and carried, a rising vote of thanks was tendered all who had in any way contributed to the success of the present meeting.

On motion of Dr. D. A. Myers, the secretary was requested when preparing the next program to place inside several blank pages for reference and notes.

On motion meeting adjourned to take up the scientific work of the sections.

The following are the section officers for the coming year: General Medicine, Chairman, Dr. F. B. Young, Springdale, Ark.; Vice Chairman, Dr. S. S. Glasscock, Kansas City, Kan.; Secretary, C. C. Goddard, Leavenworth, Kan.; Surgery, Chairman, Dr. Bacon Saunders, Fort Worth, Tex.; Vice Chairman, Dr. St. Cloud Cooper, Fort Smith, Ark.; Secretary, Dr. J. A. Foltz, Fort Smith, Ark.; Eye and Ear, Chairman, Dr. L. H. Buxton, Oklahoma City, Okla.; Vice Chairman, Dr. F. D. Boyd, Fort Worth, Tex.; Secretary, J. F. Gsell, Wichita, Kan.; Chairman of the committee of arrangements for the coming year, Dr. John Punton, Kansas City, Mo.

The meeting was not as well attended as it had been hoped it

would be, but it was so completely successful in every other way that all departed saying they would surely be in Kansas City next year.

F. H. CLARK, Secretary-Treasurer.

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BOOK REVIEW.

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HEART DISEASE AND BLOOD PRESSURE. A practical consideration of theory and treatment, by Louis Faugeres Bishop, A. M., M. D., Clinical Professor of Heart and Circulatory diseases, Fordham University, New York City. Second Edition. New York, E. R. Treat & Co., 1907. Cloth, small 12 mo. pp. 120, price \$1.00.

The Journal reviewed the first edition of this little work two years ago and at that time stated that it was a distinct contribution to the literature of medicine. The opinion of the Journal was evidently justified because we now see the book issued in the second edition. While, undoubtedly, blood pressure varies with each individual from time to time according to the conditions of the circulation, nevertheless, the general average of the blood pressure gives the physician much information as to the condition under which the organs of the body are laboring. Therefore, the study of the blood pressure as developed within the last few years is proving of considerable value to the clinician, especially in the line of preventive medicine. It is with respect to this latter consideration that Dr. Bisohp's book is to be commended, because it lays down the principles upon which the health of the patient should be promoted. As might be expected, Dr. Bishop lays the greatest stress upon the conduct of the life and the restriction of the nervous activities of patients showing abnormal blood pressure. The book, therefore, will be helpful to those of our readers who have professional and business men under their charge.

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Cardiac "Wabble" From Vasomotor Instability.

The inclined-to-criticize will kindly excuse the above. In no plainer language can we designate that well-known but peculiar functional state of the circulation due to instability of action of the vasomotors (lack of physiological balance) that calls for cactus grandiflorus, or cactin, its most desirable preparation.

The indication for cactin is not the pulse telling of cardiac inefficiency and calling for digitalin; neither, to the careful clinician, does it call for "the last"—strychnine, though one or the other, often both, are not infrequently used when not needed by those who do not clearly appreciate the condition present.

It is just the cactin pulse, indicating a heart that, by reason of instability or outside disturbance, is not doing, or is not permitted to do, its normal amount of work—a weak, irregular heart, calling for neither digitalin nor strychnine, but a remedy that will act as a governor, restoring its normal rhythm and rate.

Whether the indication be a pulse which is too fast, or too slow, too weak or too strong; if the cause is vasomotor instability, as in the tobacco heart, the heart of the drunkard, some cases of menopause, overwork, etc., no remedy in the proper condition will do just what cactin will; no remedy will so quickly restore the necessary equilibrium as this; continued as required in "dose enough", no remedy will serve you better.

The mistake the unthinking make is to look for toxic effect consequent upon the use of cactin as follows the exhibition of decided doses of digitalis and strychnine, and they are therefore disappointed when even enormous doses of it are used. The laboratory man with his frogs, rats, cats and dogs says this toxic effect isn't there—and it isn't.

A straight line can't be made straighter, and while vascular balance is produced by cactin, and in a state of disequilibrium it goes but little beyond this point, why should it be carried further if it could? What more does one want?

Cactin is a balancer, and it is this peculiar balancing action upon the circulation, preventing regional dilation that accounts for the wonderful and otherwise inexplicable effect of hyoscine morphine and cactin compound (H-M-C Abbott) as compared with hyoscine and morphine alone.

Without doubt in seven out of every ten times that digitalis and strychnine are used by the less careful, painstaking and exact, the needs of the patient and the purpose of the physician would be better served by cactin. Balance having been established through

cactin in "dose enough" other indicated remedies should be added, sufficient of the cactin being continued to maintain the effect desired.

That the appreciating clinician is well served by this remedy is evidenced by the fact that many, many millions of these granules have been consumed at the hands of the profession and nothing but satisfaction expressed—an experience which has covered a full decade.

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The Management of Convalescence.

In convalescence from acute disease, such as pneumonia, typhoid fever, acute articular rheumatism, etc., we are face to face with the problem of restoring the weakened organ to its normal condition. The blood shows a state of secondary anemia, the nutrition is lowered, the nerve and muscular tone is below par; the appetite but sluggishly answers our urging, and the digestive powers feebly respond to the demands made upon them.

It is at the dawn of convalescence, when the danger of the illness itself has passed, when the desire to live, to get strong, is highest in the patient, that the physician's reputation often hangs in the balance. Having brought the patient through an illness, many physicians are unfortunately content to rest on their laurels, and to let long-suffering "Nature" do the rest. The wise practitioner, however, knows that Nature is grateful for the proper kind of aid in these circumstances,—aid in her effort to lead a weak organism out of the bondage of illness.

And so, the far-seeing physician will look about in his armamentarium for a drug or a combination of drugs which will restore the blood, the nutrition, the digestion, the assimilation, the appetite, the weight, and the powers of resistance of the sufferer to normal, in the quickest possible time.

Fortunately, nature has provided two chemical elements, iron and manganese, which are as necessary to the system as life itself, and which, when given in the proper amounts and in the proper forms, will carry the patient through convalescence to health. In the delicate state of the digestion of a convalescent it is of the utmost importance that the forms of iron and manganese administered be such as to become absorbed and assimilated with the least disturbance of the gastro-intestinal organs. The old-fashioned inorganic preparations of iron which still figure in the Pharmacopoeias of various countries are totally unsuited for this purpose.

The scientific researches of Hamburger, Bunge, and others, conducted during the past twenty-five years have shown the immeasurable superiority of the organic compounds of iron and manganese. The organic compounds alone have been found to be absorbable in such amounts as to produce the desired action on the blood. Of these compounds the peptonate, which is an organic-chemical combination of iron and manganese with peptone in a solution, known as Pepto-Mangan (Gude) is the most readily absorbed, and therefore the most efficient preparation of iron-manganese known, and as such is used with the greatest benefit in convalescent anemias.

A point which is frequently lost sight of in considering the treatment of anema, is the importance of manganese as a constituent of normal blood, and as an element ranking only next to iron in its power of building blood corpuscles and increasing the life-bearing hemoglobin of these cells.

Campani, an Italian savant, as early as 1872, demonstrated that manganese is found in the red blood cells, as well as in the serum of normal blood, and the more recent researches of Lecan and Lheritier show that manganese forms a constant constituent of the hemoglobin molecule. Furthermore, Zalesk (*Zeitschr. f. physiol. Chemie*, 1904, page 449) showed that manganese enters the molecule of hemoglobin with same readiness as does iron, and therefore it has the same direct blood-forming power as iron. But, perhaps, the most important fact in connection with manganese, is that once having entered the red cell, it attracts iron to the coloring matter of the blood, as the recent investigations of Benedetti have shown (*Boll. Scienc. Mediche, Bologna*, June, 1905).

A consideration of the above facts will convince any unbiased physician that the preparation known as Pepto-Mangan (Gude) is made on scientific principles in accordance with the researches conducted by the foremost physiologists and clinicians within the past quarter of a century. It contains a combination of iron and manganese calculated to secure the highest possible blood-building efficiency without in the least interfering with the digestive functions. On the contrary, Pepto-Mangan is an excellent digestive tonic, it increases the appetite and promotes nutrition. Pepto-Mangan (Gude), therefore offers in convalescence the surest, most agreeable, and most prompt road to perfect health.

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SENILITY.

By Dr. L. O. NORDSTROM, Assaria, Kansas.

There are few if any subjects in the medical literature of the same degree of concern to the general practitioner, to which so little has been contributed as to the subject of Senility. In view of this fact I present for your consideration a paper on this subject, not for the purpose of adding new material to its literature, but hoping to elicit a discussion, and my paper shall have accomplished the purpose for which it is intended.

The need of a more thorough understanding of this subject is obvious when we consider the large percentage of cases which come under our observation and treatment for the infirmities of old age, and that out of this class of sufferers only about half ever call into requisition the services of a physician, because of their contention that they have reached the period of life, the condition of which is beyond human power to modify, and a destiny we all must meet sooner or later unless our lives are terminated by disease or accident. This contention that old age is not a disease prevails in the majority of physicians as well as in the minds of the laity. This popular belief is impressed upon the developing minds of childhood until it is accepted as an established fact, and consequently we neglect to do all within our power to mitigate the sufferings of old age, or to in any way retard its advent. There are other factors which are to a great measure responsible for our manifest neglect and indifference with reference to the treatment of the infirmities

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of old age. Of these I shall mention only two: First, the low estimated value of the ineptitude to material prosperity; and, Second, the disturbing element they become in society.

We as physicians can not hope to eliminate these factors in the causation of the retarded progress of the treatment of senility, but it is expected of us that we apply ourselves to the extreme limitation of our possibilities to give the decrepitude the same quality of service that we would give to those who occupy more important places in material development and in social functions.

I shall now endeavor to portray the condition of body and mind resulting from the degenerative changes characteristic of old age.

The beginning of the period of old age from the biological point of view, is at the time of cessation or decline of the reproductive function. This occurs suddenly in women at the time of the menopause, while in men there is a gradual decline from about the fiftieth year. During this period the body undergoes certain degenerative changes resulting in the gradual loss of function in the various organs.

It seems to be the consensus of opinion that the most important and characteristic of the senile changes are those that occur in the walls of the blood-vessels, especially the arteries Arteri-sclerosos. In regard to this disease Osler says, "Longevity is a vascular question and has been well expressed in the axiom that a man is only as old as his arteries."

We always find associated with old age some form of vascular degeneration, namely: atheroma, followed by calcification which is usually found in the aorta and its branches, or sclerosis or cardiac hypertrophy, or a combination of several or all.

The connective tissue of the walls of the blood vessels is increased in quantity. This produces a contraction by pressure on the blood-vessels supplying the artery, thus cutting off its supply of nutriment, which in turn causes weakening and degeneration of the walls of the vessel. This increased amount of connective tissue also leads to obstruction or obliteration of the vessels.

The degenerative processes of the walls of the vessel favors a precipitation of calcareous matter causing the vessel to lose its elasticity and contractility becoming hard, rigid and brittle, hence easily ruptured.

The heart is one of the organs most frequently impaired in old age. Its force is wasted against the rigid walls of the arteries causing an hypertrophy of the left ventricle, and when the coronary arteries are involved in the degenerative processes alterations in the myocardium or myocarditis.

The result of this condition of the vascular system is evident. We all agree that health and continuancy of life primarily depend on the provision through the blood of sufficient nutriment of proper character for all the tissues and organs of the body, and that deficiency in either quantity or quality will result in derangement of function, and ultimately in alterations in structure. Accordingly, we find in the skin of the aged a diminished supply of nutritive fluids, and an impervious nature of the vessel walls, resulting in atrophy of the subcutaneous tissue, with wrinkles in evidence; a diminished amount of secretions hence a dry skin, and deficiency of pigment—gray hair; and general atrophic changes resulting in loss of hair. There is also a loss of warmth, softness and pliability, and a tendency to malignant and other morbid proliferations.

The impairment of vision depending on opacity of the crystalline lens so common in old age can be ascribed to diminished vascular supply to the anterior region of the globe, or to interference with the osmotic action of the nutritive fluids.

The degenerative changes in the brain result in a decline of its functions; the reflexes become slower, and less intense; the organs of special sense become impaired. The hard, brittle and unyielding arteries cause a predisposition to hemorrhages with a variety of symptoms such as monoplegia, hemiplegia, aphasia, vertigo, etc.

The organs of respiration in old age are all enfeebled; the sternal segments become ankylosed; the costal cartilages become ossified; the ribs change somewhat in shape with a resulting loss of mobility and capacity of the chest and a predisposition to bronchitis, pneumonia, emphysema and hypostatic congestion.

Atrophy and degeneration of the glands of the digestive tract with diminished secretion is also to be found, as well as loss of tone of the muscular fibers of the stomach and of the intestines, allowing them of dilatation. This is particularly noticeable in the colon of man, which is a favorable harboring place for a multitude of disease germs and toxins.

Senile atrophy of the kidneys, "interstitial nephritis" results from the vascular derangement of these organs with diminished secretion and retardation in the removal of waste products from the body.

Prostatic hypertrophy so common in old men is an increased amount of connective tissue with the resulting atrophy of the glandular structures. This in turn affects the bladder by interfering with the flow of urine; the bladder being distended diminishes the power of contractility of its muscular walls resulting in chronic cystitis.

There is a lessened one of the muscles generally throughout the body, and a general fragility of the bones, and a tendency towards calcification of the cartilages, and ankylosis of the joints and structures.

I have enumerated the most important of the symptoms or manifestations of senility. Before entering upon a discussion of its causation, I shall divide it into two classes, viz: 1st, Pathological Senility, characterized by a condition of retrograde changes caused by the action of external agents or forces, and 2nd, Physiological Senility, characterized by a condition of retrograde changes resulting from some inherent defect or deficiency of the cells.

It is the first class pathological or premature senility, which is of greatest concern to us. The most prominent causes of this class of senility are: excessive muscular and mental activity, infections from fermentation or putrification from the alimentary canal, metallic and bacterial poisons, syphilis and alcohol.

To the first of these named causes we can apply the theory of compensatory endarteritis, and according to Thomas' law every slowing of the blood current in the arteries and veins of man which is not completely and at once remedied by a proportionate contraction of the media leads to a new growth of connective tissue in the intima which narrows the lumen of the affected vessel and thus restores the normal swiftness of the blood current more or less completely, and vice versa whenever the intima is unduly stretched from overexertion, the connective tissue tends to increase giving rise to a compensatory endarteritis. The infections from the fermentation and putrification in the alimentary canal, are in my judgement responsible for the majority of cases of premature senility. I shall assume that these infections of pathogenic organisms and toxins as they are found circulating in the blood current have an irritating effect upon the cells, causing inflammations with a resulting destruction of the specific cells, which are replaced by connective tissue cells, which of course are unable to perform the function of the cells which they replaced.

The metallic poisons, syphilis and alcohol disturb nutrition.

The causation of physiological senility remains in obscurity. That there is a deficiency or defect in the cell of an individual of advanced years, we cannot deny, but, what is this deficiency or defect of the cell? This is a problem the solution of which will require much effort in time to come by both the microscopist and the chemist. As yet the microscope has not shown any structural difference in the young and the old cell. Neither has chemical analysis revealed any difference in composition of the juvenile and

senile cells. It is in their biologic functions and properties that we detect their dissimilarity. It is a fact that in man after the fourth or fifth decade there is a manifest depreciation of the cells, such as nutritive failure, loss of regenerative power, and diminished resistance to bacteria and toxins. This innate depreciation of the cells ensues independent of any of the recognized external causes, and if not affected by them the delectable period of life will gradually fade into a state of physiological degeneration.

It is obvious then, that it is our duty to combat the deleterious influences that cause a departure from the normal tendency to retrogression, and to restore functional activity.

By keeping in mind the presence of perverted metabolism; the field of physiological activity is becoming progressively limited, while the dissimilative process increase is of inestimable value in outlining a course of treatment.

In conclusion I shall merely make mention of what I consider the most essential features in the management of premature senility.

Nutrition must be improved, and one of the first things for us to do with the majority of cases is to refer them to the dentist, inasmuch as digestion cannot go on to any appreciable degree of perfection when food is swallowed without being masticated and insalvated.

The dentists are certainly contributing a great deal to comfort, good health and longevity.

The diet should be selected to meet the requirements of each individual case.

In consequence of the functional insufficiency of all the organs of elimination, we have an accumulation of excrementitious matter in the system which, for the sake of good health, must be removed. This can best be accomplished by frequent bathing; massage of the skin; moderate exercise in the open air; drinking an abundance of water, and keeping the bowels active by the daily administration of magnesia or any of the mineral waters—Abilena or Carabana—also colonic flushing. Deep abdominal massage is also serviceable in restoring the proper tone to the relaxed bowels.

The indications for drugs in these cases are usually well defined. The two most frequently in demand are digitalis and potassium iodide.

I predict that the time is not distant, when the medical literature will contain glaring reports of the use of some anti-senile serum that will supply the cells with properties which will materially aid them in their metabolic, bacteriolytic and anti-toxic functions and thus restore pathological to physiological senility.

DISCUSSION.

Dr. Sheldon:—The statement that the doctor made in the beginning that there is very little written on this subject is very true in ordinary medical writing. If we go outside of medical work, there is more to be obtained. Several men have taken up the scientific study of old age and death. These investigators have shown the similarity of the changes of old age in man to that occurring in animals, plants and in the lowest forms of life. Even the preconjugal debility of the infusoria has been shown to correspond with the senile changes of man.

Now, as Dr. Nordstrum has stated, the predominating anatomical change in senility is an increase in the connective tissue elements of the body. The parenchymatous organs, the frame work of the body, and even the nervous system show an abnormal increase in connective tissue in old age.

The primary or underlying cause of the excessive proliferation of connective tissue that occurs in senility has been a much studied subject. Merkel, in 1890, in a paper read before the International Congress of Medicine at Berlin, claimed that the normal connective tissue of the body was to be held responsible for the fibrosis of old age; and, that the primary change in senility was connective tissue proliferation which resulted in destruction of the epithelial structures of the organism. Later, and more elaborate investigations, especially those of Metchnikoff, have shown conclusively that the connective tissue proliferation of senility is secondary to degeneration of the epithelial structures of the body, and that these epithelial cells are destroyed by large leukocytes called macrophags. The primary observation which resulted in bringing out this theory was made while attempting to determine the cause of gray hair. It was found that in the central canal of the hair, cells took up the pigment and then migrated from the hair, leaving it without pigment and of course without color. This key to the changes in senility made it possible to confirm or disprove the leukocyte theory by examinations of other portions of the body. Senile changes in the parenchymatous organs, the bones, the arteries and the nervous system, coincide with Metchnikoff's theory. For a time those whose observations were limited to the nervous system refused to accept this theory. Among these observers was Marinesco, who sent his specimens for examination. It was found that the leukocyte change was slight in the peripheral nerves and cord, while in the same subject, the cortex of the brain showed very plainly the action of the macrophags. All observations have confirmed Metchnikoff's views, and have shown that the changes of senility are more marked in certain portions of the body than in others. The vascular system is particularly affected. Dr. Nordstrom has called attention to this important observation and has reminded us of Cazalis' statement that "man is as old as his arteries." Clinically, the condition of the vascular system is of importance, for it is a quite reliable index of the patient's reserve force. Now, since we understand fairly well the minute, as well as the gross changes, occurring in old age, the next question that presents itself is: What forces or conditions are responsible for this undue activity of the macrophags in the aged? We do not know. The answer turns us back to the law that the inevitable termination of life, in both animals and plants, is practically death. While this law is perhaps no more true today than it has been in the past, it seems that the life of man has been shortened; that instead of living one hundred or more

years, we live but 70. This suggests that there has been brought about a premature senility that is in a sense pathological. What are the causes of this premature senility? I shall mention two of them: modern civilization and the large intestine. Although man is comparatively a recent arrival on this earth, he has made great progress in the last few centuries. Human art has, in many instances, been able to surpass nature; while modern methods of nourishment and shelter are superior to those of our ancestors, nature has attempted to keep abreast with our artificial methods but it has been unable to do so, and the result has been a number of physiological disharmonies which progress until they become pathological, produce a premature senility and shorten life. Civilization has added to our comforts and pleasures at the expense of our years. There is abundant evidence of the disharmonies in the constitution of man in human and comparative anatomy. The wisdom teeth, the jaws, the lower or grinding portion of the stomach, the appendix and cecum, are today rapidly undergoing atrophy for the reason that nature has either altered or abolished their functions. The large intestine is frequently to be held responsible for premature senility. In the large bowel, stagnation results in the formation of poisonous chemical compounds which are absorbed and are responsible for the changes that result in the degeneration of epithelial tissue and its destruction by microphags, and the subsequent connective tissue proliferation—the characteristic changes of senility. The large intestine in man has become an unnecessary organ. It is possible that in previous centuries it functionated by digesting cellulose and assisting in absorption; and, it may be that today it is a necessary organ in horses, cattle, rabbits and some other animals, but in man it is only an organ of convenience acting as a receptacle, as does the urinary bladder. It constantly contains products of fermentation, some of which are poisonous. The advantages of having a colon in no way compensate for the disadvantages. In animals, the presence or absence of a large intestine bear a direct relationship to the duration of life. Birds which live in the air, so to speak, and therefore do not require a large intestine for a receptacle are not provided with a large bowel. They are long-lived. While birds that do not fly, have a large intestine, and their lives are of brief duration. The crow, parrot, swan and other flying birds are long-lived; while the ostrich lives only 35 years—a very much shorter time. Is the large intestine responsible for this marked difference? In animals, reptiles and birds the length of life bears a definite relation to the presence or absence of a large intestine. * * * * *

(Time called. Motion carried to go on.) * * * * * Now, if I say anything more, I shall have to talk of the pathology of senility and summarize it in a very few words. We see today that we apparently have an increase in appendicitis and an increase in carcinoma. We see that these peculiar diseases involve certain organs and are found in certain locations. We cannot explain it on any chemical or bacteriological basis. We see that ulcer of the stomach, in almost every case, occurs in the lower part of the stomach. Why? Now, going back to physiology, you will see that the lower portion is a grinding organ purely and simply. It has been used in previous generations to grind up food. We do not use it any more; consequently, the muscular layer is undergoing atrophy from disuse, while the fundus of the stomach is still active and not often the seat of disease. This might be the underlying explanation. We know that the glands in the lower end of the stomach are of little value and that the lower portion of the organ is wasting; but, we fail to recognize the connection between

atrophy of the stomach, and carcinoma and ulceration. In the human teeth we have an example of the disharmony between civilization and nature. Our ancestors had unnecessary teeth, and our wisdom teeth are disappearing. They are absent in 10 per cent of Europeans; and, those of the upper jaw are absent in 18 to 20 per cent of the so-called highly civilized individuals. They appear late in the development and are imperfectly formed. All of these things explain why the wisdom teeth are often causing trouble. There is no useful function of these teeth to offset their disadvantages; and, it is probable that in time, nature will complete the process of their elimination. The vermiform appendix is another rudimentary organ that today serves no useful purpose. It is of low resistance for the same reasons that apply to the wisdom teeth; and, on account of its anatomical location, is causing a great deal of trouble. It is probable that this organ, together with the cecum, has been necessary sometime in the past; but, today appendicitis stands as an example of a disease made possible because we have artificially rendered a portion of our anatomy easy prey for one class of our natural enemies—pathogenic bacteria. The cecum is not so detrimental as the appendix, but it is unnecessary for our maintaining a physiological balance. It is of interest in comparing man with the lower animals—for the cecum in certain animals, particularly the rabbit, is a useful organ. The entire large intestine, like the appendix and the cecum, has not only become an unnecessary organ, but a harmful one. We no longer need it to digest cellulose, while its power of absorption is secondary and superfluous. The size of our large bowel is out of proportion with the quantity and quality of our food. It is too large. This disharmony results in constipation, stagnation, undue fermentation, auto-intoxication and premature senility. Our digestive disharmonies and our short life, with the instinct to live, and the fear of death, constitute the greatest disharmony in the constitution of man. What remedies are to be suggested to harmonize these disharmonies—to prevent premature senility and prolong life? We cannot turn back to the methods of our remote ancestors. The vegetable diet does not solve the problem. We are operating for appendicitis, carcinoma and ulceration of the stomach; we are doing something to relieve suffering and prolong life; but, we are not diminishing the frequency of occurrence of these diseases. Surgery might go one step farther and short circuit the large intestine by implanting the ileum into the sigmoid flexure. This would prevent constipation and undue stagnation, and to some extent, fermentation and auto-intoxication. To my knowledge, three of these operations have been performed with gratifying results; and, in the not distant future, this operation may become a recognized surgical procedure.

Dr. Nordstrom:—It is too late now to say very much. I appreciate highly what has been said by Dr. Sheldon.

SOME ESSENTIAL POINTS IN THE DIAGNOSIS OF NERVOUS DISEASES—WITH REPORT OF CASE.

By Dr. O. D. Walker.

The title of this paper at once suggests that it is [not exhaustive; there is not the time, nor would this be the proper place to take up in detail the many essential points in the diagnosis of nervous diseases.

In studying a given case of nervous trouble we need, as a rule, to be more particular in following an orderly outline than in any other form of disease. Hence, the family and personal history, alcoholism and syphilis are to be especially noted. Motor and sensory disorders both general and special; electrical reactions, present conditions, reflexes whether exaggerated, lessened or abolished, symptoms both subjective and objective, swaying of the body, while the gait, whether ataxic, spastic or that of simple weakness, all furnish valuable data essential to correct diagnosis. In this paper, however, I shall confine myself to a few points touching organic and structural diseases of the brain, cord, and peripheral nerves. Functional and nutritional diseases must be passed for lack of time.

The researches of physiology and pathology have done much in advancing our knowledge in all branches of medical science, and certainly this is true in nervous diseases. The same form of pathological lesions will be found in nervous structure as obtains in other tissues.

In no class of diseases is an intimate knowledge of the anatomy and physiology of the structures involved so essential to a correct diagnosis as in those affecting the nervous system, and especially is this true of organic and structural diseases of the brain cord and nerves; but with this precise knowledge in anatomy and physiology a definiteness can often be reached in nervous diseases not possible elsewhere.

A large per cent of general practitioners fail utterly to make a differential diagnosis between the various forms of paralysis. A flaccid or spastic condition means nothing, a lost, lessened, or exaggerated reflex suggests no location of lesion. He may observe that in one case of paralysis there is atrophy with vaso-motor changes, while in another atrophy is not noticeable, but it is all

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the same to him so far as having a definite idea as to the part of the nervous system involved. This comes about, not from lack of interest in nervous diseases, nor yet from a want of a comprehensive view of medicine in a general way, but rather from a lack of knowledge of the anatomy and physiology of the nervous system. And, this knowledge cannot be attained in the ordinary superficial way in which much medical study is carried on, but only by careful, persistent application, so it comes about that many nervous affections are treated upon general principles with but little satisfaction to the doctor and small benefit, if not actual injury, to the patient.

In the spinal cord we find thirty-one segments, piled one on top the other, each segment having a pair of spinal nerves and each possessing a motor, vaso-motor, trophic and reflex center. Going out from each of these centers, located in the anterior horns of the cord, we have the lower neuron which carries the efferent impulses to the periphery and also contain the trophic and reflex fibers, if indeed we have separate fibers for each of these. The afferent or sensory fiber from the periphery to the cord, completes by its connection with the neuron of the efferent fiber, the reflex arc which must be unbroken in order to get any reflex whatsoever to the part. With this reflex arc complete and a normal muscular tissue, we will have the cord acting as a reflex center and with inhibition from the cerebrum intact, we have a normal reflex, while with inhibition cut off by disease in the brain or the motor pathway through the cord, we have exaggerated reflexes. With disease involving the anterior horns of the cord, thereby destroying the nutritional center of the lower neuron, as in poliomyelitis, we have a break in the reflex arc between the cord and the periphery; also a disturbance of the trophic and motor centers and we get lost reflexes, flaccid paralysis and rapid atrophy.

One must have a correct understanding with reference to the brain blood supply in order to properly appreciate and diagnose those focal diseases of the brain dependent upon arterial disease. When we know that the branches given off from the great basal arteries after entering the brain stem, do not anastomose, but are terminal in character and are distributed to a portion of brain tissue represented by a pyramid with its base toward the median line, from base to vertex, and further that the danger from hemorrhage will be found principally along the track of these branches passing up from the basal arteries and distributed especially to the lenticular

and candate neuclei and internal capsule, a small clot along this pathway involving, as is frequently the case, all the fibers from the motor area of one side; by understanding these points we would scarcely be led into trephining over the entire motor area, as I have known to be done, for the removal of a supposed cortical clot when the case gave no history of traumatism, but rather one of undoubted syphilitic infection and the lesion had happened several months previous to the surgical procedure.

The brain is also the great psycho-motor and sensory center; it is the cortex which receives and registers afferent impressions and from which are sent out the voluntary efferent impulses. This gives us, so far as the motor fiber is concerned, a neuron in the cortex and its neuraxon which is projected down the cord ending by arborization or contiguity about the lower neuron in the anterior horns of the cord: this, we term the upper neuron, and so far as nutrition is concerned, is separate and distinct from the lower neuron.

The brain, too, must be looked upon as the inhibitory center, as it is also the center for the higher psychical functions. This inhibitory influence controls the reflexes and follows the motor pathway through the cord, through the crossed pyramidal tracts.

Keeping this in mind, we readily see why in diseases affecting the brain along the cortical motor pathway and also the diseases of the cord, involving the crossed pyramidal tracts, we have lost inhibition and consequent exaggerated reflexes and accompanying this state of reflexes a spastic condition.

Our knowledge of cortical localization is not by any means perfect, only within the past year or so there has been a revision of opinion regarding the motor area and now instead of the motor area being on both sides of the fissure of Rolando, particularly in the ascending parietal, it is now believed to lie anterior to Rolando in the ascending frontal convolution.

The cortical centers concerned in speech are the Visula, Auditory, Receptive and emissive speech centers, the noun or naming center and motor graphic center. Without taking up time to locate or describe each of these cortical areas, I will speak of but one: The noun, or naming center, believed to be located in the third temporal convolution of the left brain, except in case of left handed people, when it will be found upon the right side. As the name of this center indicates, this is where the names of objects, both common and proper, are registered and memorized.

A very interesting case illustrating this center fell into my hands several years ago which I will now proceed to report: J. H. presented himself for examination. He was in good physical condition, complained of nothing special except the loss of memory for names of people, places and objects, which loss he said had existed since the injury. The history of the case was that a few months previous in an altercation he was struck upon the left side of the head with a brick; was rendered unconscious, picked up and carried to a doctor's office where it was found that he had sustained a fracture of the skull over the left temporal region. An operation was performed in which the fractured skull was moulded back into place as well as possible and a few small, loose pieces of the bone removed. The man made an uninterrupted recovery so far as the wound was concerned. Upon examination I found a linear scar running in an anterior-posterior direction just above the left ear, the lobe of the ear having to be depressed to see the scar. The man was strong and healthy looking. Further examination showed no paralysis or sensory disturbances; no defect of word hearing, word sight, motor agraphic, motor or conduction of speech. His articulation was good, speech fluent, no misplacing of words, but whenever in his conversation he had occasion to use a common or proper noun he would hesitate, and after considerable effort to recall the name he would give it up. He could not recall the name of anyone of his immediate family just after the accident, but three months later when I saw him he knew the names of some half dozen people with whom he had been in daily contact. These names he had memorized by constant use, and perhaps the right brain had been educated to this extent.

A common object, as a pencil, knife or key, he knew the use of but could not name the object, but recognized the name when correctly called. He also knew the use of an object or instrument. A pencil he knew was to write with. On being shown a knife he said, "I can't call the name, but I know it is to cut with." "A key," he said, "was to unlock a ——" Here he would stop, not being able to call the name "door."

I tested him with names of towns along the river with which he had been very familiar for years, and found his memory for names entirely gone. Right here I must stop with this most interesting case. I got a promise from him to return to the hospital for an operation one week later, when I expected to open up over the site of the traumatism, feeling certain that I would find some-

thing, maybe a depressed bone, perhaps a spiculae of bone driven into the brain, or a blood clot making pressure over the cortex at this point, and the removal of which might again allow the cortex to functionate. His failure to return and removal from the city defeated my purpose. The location of this injury was directly over, or external to the third temporal convolution. I have since felt that here was a case that might have added something of knowledge to our fund of cerebral localization.

In this paper I have attempted to state some of the essential points in the diagnosis of nervous diseases; points which to me have been helpful. There are many more not touched upon, but what I have tried to say here will obtain also upon other points not mentioned, and that is, that the differential diagnosis of nervous troubles require a more precise knowledge of the normal anatomy and physiology of the nervous system than is necessary in any other class of diseases.

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The following articles will be added to the list of new and non-official remedies approved by the Council on Pharmacy and Chemistry: Taka-Diastase (Parke, Davis & Co.,) Colalin Laxative (Rufus Crowell & Co.,) Maltzyme Plain (Malt-Diastase Co.,) Maltzyme With Cod Liver Oil (Malt-Diastase Co.,) Maltzyme With Cascara Sagrada. (Malt-Diastase Co.,) Malzyme With Iron, Quinia and Strychnia, (Malt-Diastase Co.) Maltzyme With Hypophosphites, (Malt-Diastase Co.,) Maltzyme With Yerba Santa, (Malt-Diastase Co.,) Maltzyme Ferrated, (Malt-Diastase Co.)

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THE SIGNIFICANCE OF HYDROCHLORIC ACID IN GASTRIC CARCINOMA.

By JOHN G. SHELDON, M. D., Rosedale, Kansas.

Since the advent of stomach analysis as an aid in the diagnosis of disease, various clinicians have attached more or less importance to the diminution or absence of hydrochloric acid in the gastric contents in the diagnosis of gastric cancer. While, as a rule, the h c l test has not been looked upon as being of decided value in making a diagnosis; the diminution or absence of the stomach h c l has been considered more or less characteristic of cancer of this organ.

During the last 12 months, Moore (12), Alexander (2), Kelly (3) and Roaf (4) have shown that the diminution or absence of hydrochloric acid in the gastric contents is in no way characteristic of cancer of the stomach. These investigators have found that deficiency or absence of h c l is the rule in cancer located in any portion of the body, and their clinical observations show that cancer in the uterus, in the breast, or in any portion of the body is associated with the absence of h c l in the stomach as frequently as is gastric carcinoma. While these observations apparently diminish the diagnostic significance of hydrochloric acid in gastric cancer, those who have studied the subject after carefully considering the facts, that the h c l in the stomach is often markedly diminished or absent in pernicious anaemia and wasting diseases, and as Fiefschuntz (5) has shown, h c l may be normmally diminished in individuals over 50 years of age, still express the opinion that deficient secretion of h c l occurs more often in cancer than in all other conditions and while this gives us no aid in diagnosing cancer of the stomach from cancer in other portions of the body, it must be looked upon as characteristic of cancer in general and of considerable diagnostic significance.

The cause of the diminution or absence of h c l from the gastric contents in carcinoma has been studied since Robert Von den Vel-den (6) first called attention to it in 1879. The early observers thought it resulted from stenosis of the pylorus. It was believed that when a gastric cancer occluded the pylorus a profuse catarrhal secretion in the stomach followed, and that this neutralized the hydrochloric acid. This theory obtained until 1887, when Honigmann

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(77) Von Noorden (8) disproved its correctness by showing that in stenosis of the pylorus due to non-cancerous conditions h c l was present; and that in many cases of gastric cancer h c l was absent when no pyloric stenosis existed and no gastric dilatation has occurred.

Another theory advanced to explain the absence of h c l in gastric carcinoma, was that there was poured into the stomach, from the ulcerating cancer, a material that neutralized the acid. This view was apparently strengthened by the work of Beebe (9), Frisbie (10), Loeb (11) and Cowles (12), who showed that cancers contained an excess of potassium. The theory, however, was soon discarded principally for the reason that many times the h c l is absent in cancer of the stomach before ulceration has occurred.

In 1903 Matthiew and Roux (13) stated that the absence of h c l in gastric cancer was due to atrophy of the gastric glands. Vieregge (14) coincided with this view, but most authorities dissent from it—stating that in cancer of the stomach the glandular atrophy theory is not substantiated by histological examinations.

It seems that the explanation for the absence of h c l from the stomach in cancer, is to be found in the chemistry of the blood, and not in local conditions in the stomach. The secretion of h c l in the stomach is, according to Moore (15), Wilson Roaf (16) and others, dependent upon the H or acid ions in the blood. If these are neutralized by OH or basic ions, the secretion of the acid will be interfered with. It appears that carcinoma in any location in the body produces definite blood changes—increasing the basic ions in the plasma and lymph. Micheli (17) and Donati have shown that cancer extracts are haemolytic; and Petry (18) and others, have observed that during cancer haemolysis basic substances are formed. Hober (19) called attention to the fact that these changes diminished the H ions in the blood; and Emerson (20) first suggested this theory as the explanation of hypochlorhydria and anhychlorhydaia in cancer. While this theory cannot be accepted as final, clinical observations seem to confirm it. Alexander, and those who have worked with him, report 17 cases of cancer in portions of the body, other than the stomach, showing marked diminution or absence of h c l in the gastric secretion. I have found absence of h c l in two cases of advanced cancer of the rectum. I found it absent in three cases, and markedly diminished in one case, of cancer of the uterus. It was also absent in two cases of cancer of the breast; and diminished in two others.

It is stated by Roaf that the h c l of the stomach does not reappear after operation, but he does not record the number of observations touching on this point. In a case of cancer of the breast, with absence of h c l in the stomach, the acid had reappeared six months after I had removed the breast. This is the only post operative observation I have thus far made regarding the reappearance of h c l after operation.

In the light of these recent clinical and chemical observations, the diagnostic value of h c l in the stomach contents in gastric carcinoma is of minor importance. Its absence or diminution must be considered no more characteristic of cancer of the stomach than of cancer in other portions of the body. It is of value in making a diagnosis only when cancers of the stomach are divided into two classes: First, those following gastric ulceration; Second, those not preceded by ulceration of the stomach. In gastric carcinoma not preceded by ulcer, h c l may be expected to be diminished or absent early in the disease. While in gastric cancer developing on the site of an old ulcer, that has been associated with hyperchlorhydria, the tumor may be well advanced and still h c l be present in the gastric contents.

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DISCUSSION.

Dr Shannon:—I do not know that I shall attempt to discuss these questions. I believe the work is still in the experimental stage. If this was not due to atrophy of the glands, it might be of some value. It would be a very good test for determining whether or not our operation has been successful. The doctor reports one case where the acid was not successful.

Dr. Sheldon:—I have nothing more to say but a word or two in response to Dr. Shannon's observation that this matter is in the experimental stage. My object in presenting this is that the atrophy of glands is no certain diagnosis of gastric carcinoma, that there is a change in the blood in most cases. It might be a test to determine whether or not our operation had been sufficiently able to cure the patient. We ought to take the right view of this matter, and wash the stomach out and determine whether or not hydrochloric acid is present in the stomach. Make this examination before operation and afterward, that we may determine. This thought that I have set before you is largely a theory, but it should be determined what it means.

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Dr. J. M. Winegar of Hamilton read a paper on "The Sunflower." There was no discussion.

THE SUNFLOWER.

From the humble flower of the plains, to the classical emblem among flowers of our state, the one chosen bloom among all the flora, to wear the golden crown of royalty—the queen of flowers, to preside at functions of state and whenever her wand is raised Kansas salutes her. The prototype of aggressive wealth, the synonym of undeveloped possibilities and power; no hot house plant, she lifts her head and asserts her sway in great adversity, teaching a lesson by example; with no well defined or potent alkaloid of healing within herself discovered. Yet her name suggests a force whose potential is maintained by the dynamos of nature, "sunlight." Sunlight is nature's most active antiseptic and germifuge. The greatest in sanitation, the noblest preventative medicine and least heralded of them all. The handmaids of boards of health and the X in their equation. Fluorescence and radiation, those unexplored and unexplained phenomena of light may be the golden key to unlock many secret doors and marshal truths but guessed at now.

To find the how and why of alkaloids and leucocytes and phag-

ocytes and cells and apsonius in that evasive chemistry of life is difficult and hard to do, but worthy of spartan effort. Nature, always alluring, beckons us on to study deep psychiatry for ways and means to attract and hold the minds and remove or change or pluck out the thoughts that disturb, annoy, harrass, when no lesion is apparent, requires a greater delicacy of skill in touch and technique in such surgery than to amputate a limb or perform a laparotomy.

To scientific research we must look for the Rosetti stone to decipher nature's hieroglyphies and to correctly read her language; to teach and preach the laws of health and prevention of disease continuously, to establish a centralized propaganda that reaches every home within the state and screens from contagion by laws of quarantine, to place competent guardians at the source of food and drink supplies, to see they are not polluted, to cause to be abated any nuisance that may menace health is no mean task accomplished, but worthy emulation.

The end suggests the means to destroy the brood before they breed; to banish the hosts of disease and death, which if allowed free sway would mark their trail with corpses strewn and grinning skeletons would laugh at man's neglect to use the means now well defined. In these affairs it often is that those who profit most yield least reward and lesser still of gratitude. When in the future that Colossus, The Sunflower, is raised goddess and stands guardian at the front door of our state, a tribute to public hygiene and preventative medicine, holding in her right hand the imperial bloom wooing the sun, her left hand reaching ever "upward to the stars" with palm extended to grasp more light, a symbol of education, health, prosperity and happiness, then the medical men of Kansas can put on the ermine they have so nobly won.

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Announcement.

Dr. Sawtell announces the removal of his office from the Rialto Building to rooms 705 706 Bryant Building, Corner Eleventh and Grand Avenue. Home phone, Main 5787.

SCARLET FEVER.

By G. M. Anderson, Beverly.

Gentlemen: The object of this paper is, not to tell what scarlet fever is or the treatment for it, for the text-books tell this better than I can in the time allowed me, but to impress the dangers of a mild epidemic of scarlet fever and to urge the efficiency of a careful quarantine. The idea is almost universal with the public that scarlet fever and scarletina are two different diseases.

They consider scarlet fever a dangerous disease and recognize that it should be quarantined, but a mild epidemic they will class as scarletina or scarlet-rash and will honestly think these cases should not be restricted.

They do not know as you do that these two are one disease and I think it will never be properly controlled until they do know this, because people dislike very much to be quarantined, especially if they consider it unnecessary, as they do if the disease is a mild scarlet fever. So they avoid quarantine by not employing a physician, and their neighbor's children get the disease and his neighbor's children and so it spreads. Then there is a severe case and a death, due to the first case not being isolated, and farther back, due to people thinking scarletina is not scarlet fever.

I think two reasons will explain the prevalence of this idea.

First: We have the two names for one disease and although we use them interchangeably the laity does not.

Second: Most epidemics are very mild but we occasionally hear or know of one much more severe, so that it looks like two different diseases, and then the fact of having two names completes the confusion and people are positive that the diseases are separate and distinct. I may not have made a plain case of this, but so plausible is it as it transpires that many physicians who have seen only mild epidemics have made the error of assuming that advanced therapeutics and a better treatment of the disease has absolutely modified scarlet fever, and that it is not the same as is described by authors of one hundred years ago and this mistake has been made by some of our ablest men.

About thirty years ago there was a practitioner of large experience assisting in the authorship of a text-book on practice, and in writing of scarlet fever he said something near as I have given

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above, that a better knowledge of the nature and treatment of scarlet fever has made it possible for us to reduce the mortality very much, and it is a disease we no longer dread as did the physicians of a generation ago. While this article was in the hands of the publishers a severe epidemic of scarlet fever broke out in the city where this man was practicing, and he was called on to treat many cases and he lost a number of those he treated. Before the book was printed he rewrote the section on scarlet fever and made no claims that it was greatly modified or that his treatment was better than used years before. In many mild epidemics of scarlet fever isolated cases occur which are very severe, and in which death occurs almost before treatment can be instituted.

I shall not attempt an explanation of this great difference in the severity of different cases, but we all know there is this diversity also many cases in these milder epidemics are left deaf or with kidney lesions or suppurating glands or some localized trouble.

I wish to give the history of four fatal cases which have come under my own observation in the past year, illustrating the dangers of this disease.

First: A boy five years old had scarlet fever in January, 1906; not severe. I was not called to see him at that time. About three months later he was out with his father one day and got wet and soon had a severe nephritis, from which he died last June.

Second: A boy two years old was taken sick in March last. A physician was called and pronounced it scarlet fever, which was prevalent in the town in a mild form, but he did not have the family quarantined. The little fellow died in less than a week, and they were not quarantined until two days before his death, when I was called, although other members of the family had the disease for fully two weeks previous.

Third: A case I may not give correctly, as I was not the attending physician. A boy four years old took the disease from a younger child which was said to have scarlet rash, and he died in five days. April last.

Fourth: The last of November past my wife and four year old girl went to Wichita for Thanksgiving. There was a child on the train a little sick. Three days later our little girl took violently sick with scarlet fever and died in less than four days.

The only possibility of contagion that we could trace being some one they met, probably the child mentioned.

These four cases given show plainly two grave dangers of these

mild cases; one the danger to the individual himself of some complication following, of which I have given an example of only one, —i. e., Nephritis; and the other the danger of another contracting the disease and having it in violent form. If my paper were to close here I think my view of scarlet fever could be called a very pessimistic one, for I do not think there has been the advance made in the knowledge of the cause of scarlet fever that there has with many other of the diseases we treat, and I doubt much if our treatment is greatly more effective than the treatment formerly used, but one thing we have learned, and that is that quarantine is more effective here than anywhere else.

With very moderate precaution there will be no spread of this disease except where people are crowded.

To show how easily controlled by quarantine I will give two cases from my own practice within but little more than a year.

March, 1906, a little girl in Beverly had scarlet fever. No other children in the family. Quarantined. There were no other cases in town at this time, and none following. In December, 1906, I had scarlet fever and was under quarantine four weeks. There were no other cases in town at this time and none following.

If I could describe some new operation that would save a few lives each year you would think it wonderful, yet we, working together, can save some lives every year in Kansas by the plan I have tried to outline. That is by teaching people that there is no scarlet rash—that these cases are scarlet fever and are dangerous, and by impressing the fact upon them that it is criminal to carelessly spread this or any other disease, and last, by promptly quarantining the first and every case we see.

If we do these three things we will certainly save some lives that would be sacrificed under present conditions.

DISCUSSION.

Dr. Brookhart:—I am heartily in favor of the doctor's paper and what he has to say about quarantine. In the last few months I have had several cases of scarlet fever. I have had a great deal of trouble to keep patients quarantined: and, it is largely due to the fact that there are a great many doctors who say "scarlet rash" is not scarlet fever. I was called in for suppurating glands of the neck. I opened five abscesses in the neck of that little child and her people had thought they only had "scarlet rash" in the family. It seems to me that the use of the term should be discontinued, for it leads to great harm.

Dr. Robinson:—There is a great deal of trouble as the result of the mild cases of scarlet fever. If the children are not much sick, the family

does not employ a physician. They get well in a few days. Nothing is done toward quarantining, some other child is exposed to the disease and dies from its effects. I was called to a place to see a child that was sick from some intestinal trouble. I observed that the epidermis had peeled from the hands, the face and the body. I have reason to believe that the whole family of eight or nine children had had scarlet fever. During my rounds in the next few days I found several families who had had scarlet fever without employing a physician. In such cases, we are practically powerless to enforce quarantine. We find the same trouble with smallpox. I had an experience in my town. I had a family quarantined who had smallpox. I had my family vaccinated; they broke out as a result of the vaccination; and, this family whom I had had quarantined wanted to have my family quarantined on account of it.

Dr. Browne, Leavenworth:—I want to tell of two cases that I had. One was that of a little girl who had a very light case, practically not sick at all—would not go to bed. In taking care of her, we told the mother what to do in case another child got it. In two or three days after the little girl broke out, we went there and saw the second child, and inside of six weeks, it was dead. Probably from acute nephritis, as there was no urine passed after the child showed that she was sick. This was during a very mild epidemic of scarlet fever in Leavenworth. Many had it, but were not quarantined. I was severely criticized for quarantining people who were not very sick. I insisted on quarantining everybody who had a suspicious looking rash at that time. I have been told in another case that a physician told the family that the child had "strawberry rash." If you can tell me what "strawberry rash" is, I wish you would. The child was not very sick, but they thought it would be better off out on a farm; so they sent it out to visit some cousins. A little five year old child whom I knew well (one of the cousins) was dead inside of two weeks. She had suppurating glands of the neck and died as a result. If there is one thing I want to say it is, let us be strict in our quarantine. It is better to quarantine one dozen unnecessary families than to have one death as a result of not enough quarantine.

Dr. Porter:—I do not think that quarantine is sufficient. After quarantine, disinfection is necessary. I remember an epidemic that occurred in my practice. I traced it to the opening of a book that had been played with by children who had had scarlet fever two years before. The book was laid away carefully; and, after two years' time was brought out to show pictures to some children. In three or four days, they had scarlet fever and an epidemic was the result. Had they been thoroughly fumigated, several lives would have been saved. Another thing is: A great many people think that as soon as the rash has disappeared, the patient should be turned loose. This is not a fact. Every case should be quarantined at least four weeks; regardless of appearances. If there is anything at the end of that time that seems to be wrong—abscesses, discharge, etc.,—they should still be confined in quarantine. It is one of the easiest diseases to quarantine that we have to deal with. The very mildest form of the disease in one may produce the severest form in another.

Dr. Best:—A few years ago there was a case of scarlet fever happened in a very prominent family in our town. The child's grandparents were over in Germany. A child in a friend's family died over there. The grandparents wrote of it to this family; and, this child suffered exactly like it. It lived only about four days. The fever was 104. There was no history of that child's ever having been exposed. Would it have been possible for those germs to have been brought across the ocean in that letter? It caused considerable discussion at the time it happened. I should like to know. There is one other little point. Children, of course, should be kept very carefully in the house after having the mildest case of scarlet fever. The mildest case may die later of the disease. The mild cases often develop the most fatal sequellae. That is why this disease has caused so much discussion. It is not many years since they almost denied that there was such a disease—it affected people in such varied ways that it was difficult to learn of it.

Dr. Blasdel:—I was just wondering before the brother got up on this matter. I had a case similar to that he related, although the infection did not come so far. I was called to see a girl four or five years old with unmistakable scarlet fever. She ran the usual course and got well. No one else became infected. The family absolutely knew of no place where they had any scarlet fever in the neighborhood. After I had discharged the case, there came a letter from a brother who told of their having an epidemic of scarlet fever in their vicinity. Just before the little girl got sick they had received a letter from this brother. Undoubtedly the letter had carried the germs to the little girl.

Dr. Dillon:—I have no criticism to offer to the paper the doctor gave. There are a few things which might be added. In the first place, why do the people think that there is a scarlet rash, a scarletina, a rose rash, all different from scarlet fever? Simply because the physicians have told them so. All the doctors who come to the medical societies know this. Those who do not come, do not know; and, they are teaching the laity this today. One thing more; regarding the vitality of the germ. I suppose that most of us can go back into our experience and tell of cases of its having been transmitted in these curious ways. It would take the whole afternoon and then the story would not be half told. If the germ can be carried for one way in a letter, it may be carried clear across the ocean in a letter. I know of a case where the family laid away the clothes of a little child who died of scarletina; and, a few years after, these clothes were given to another child and this child started an epidemic. However, I do want to state that possibly the doctor who wrote this excellent paper has been negligent himself. He had the disease himself only a few months ago, if I understand him correctly. Evidently, the disease had been lingering in the house from the death of the child until the father took sick. You must kill the germ; or it may live twenty-four months and start an epidemic.

Dr. Barnett:—I simply want to refer to a case that happened in my practice a few years ago. The case was one that was said to be a mixed infection of scarlet fever and diphtheria. The child had a box of trinkets.

The little one died. After the death of the child, that box of trinkets was sent to a brother who had four children. In the required time—almost to the day—those children took down with a mixed infection of scarlet fever and diphtheria. That is authentic. The case was thoroughly investigated. The physician should in all cases of rash give the public the benefit of the doubt of the diagnosis. It is better to do injustice to one family and place them under an unnecessary quarantine than to do injustice to a whole neighborhood by not quarantining one family that should be quarantined. You may earn enmity; but, what does that amount to if you are doing your duty? About a year ago, I was called to see a girl about 13 years old who was in convulsions. I could get no case history. After I succeeded in bringing her over that crisis, I then tried to find out the possible cause. She had had German measles the Christmas previous, the doctor said it was German measles. I got a specimen of the girl's urine, made an examination, and found that I had a case of nephritis caused by a case of scarlet fever diagnosed as German measles. That girl, with all the careful treatment possible, still shows traces of that trouble. I believe that in many cases an epidemic of scarlet fever is caused by a careless diagnosis. Many girls working here in the city in department stores, have scarlet fever so lightly that they never know they have it. They wrap packages and send them broadcast over the city. What is the result? Epidemic scarlet fever.

Dr. Goddard:—My experience is that history repeats itself pretty often. Forty or fifty years ago at the first medical society I ever attended, I must have heard this same discussion. It is the same old story.

Dr. Anderson:—The point of disinfection was well taken. Quarantine is of no use unless we disinfect afterward. I read a notice in the Topeka paper that stated that a man had been quarantined for scarlet fever for two weeks. He did not want to disinfect until his fancy chickens were hatched. Quarantine is very often too short. While it is true it is sometimes taught by physicians that these various named diseases are different, I think it is more often taught by not teaching anything in regard to it. In regard to my own case, where the doctor spoke of negligence. That was merely a misunderstanding. The baby died the third of April; and, on the seventh, I took sick.

HOW NOT TO DO IT.

By EDWIN TAYLOR SHELLY, M. D. Atchison, Kansas.

While no great crying need may exist for additional evidence confirmatory of the truism that "the next best thing to knowing what to do is to know what not to do." another proof of the truth of this adage nevertheless will be submitted. Spurred on by the urging of such men as Denslow Lewis, Prince A. Morrow, Chas. E. Woodruff and others, that medical men should take it upon themselves to disseminate throughout their respective communities much needed information concerning the venereal peril, I sent the following communication to two daily papers in succession. The reception which it received at the hands of the Atchison Daily Globe is portrayed in the following clipping from that paper:

"One of the physicians in Atchison has sent a well-written and important letter to this office which we cannot publish, as it relates to the sexual question. There is no other social question of equal importance, but newspapers must remain quiet with reference to it. If we should publish this letter, there would be a commotion; many people would be horrified. But the letter is true, very important, and has the endorsement, we are informed, of six Atchison physicians. Young people are denied much knowledge that is of the greatest importance. It isn't taught in the schools; it isn't referred to in the newspapers or magazines. We believe the letter should be published, but are afraid of those who are of a different opinion. All of us, by the way, are influenced by those who entertain notions we do not accept."

The Kansas City Star returned the article with only a stereotyped declination to publish it. The following communication is therefore an example of how NOT to attempt a matter of this kind:

DANGERS OF UNCHASTITY.

Perhaps the most difficult matter to treat acceptably in a lay publication is that of unchastity, particularly from any other than a purely moral aspect. Indeed, nothing but the superlative importance of this subject to the rising generation could induce any one with the least dread of the frowns of Mrs. Grundy to venture upon so unconventional and thankless a task.

While nearly every one who has reached the years even of adolescence realizes quite thoroughly the advisability, from a moral standpoint, of leading a chaste life, there are nevertheless, still too many persons who look upon chastity as an ideal condition which should be maintained inviolate by one sex, but which may

be demanded with less rigidity of the other sex. And yet there is no reason, physical or ethical, why the two sexes should not be expected to occupy exactly the same plane in this regard. Nature, at all events, is impartial in the matter, and is as ready to punish infractions of chastity in the one sex as in the other, although, it must be confessed, with unequal severity, at times. Of this punishment this article is especially to treat.

There are two prominent diseases which may result from illicit relations. One of them is chiefly, although not entirely a local inflammatory disorder, while the other is mainly a constitutional infection requiring the continued treatment of years for its eradication. Even then it often reasserts itself in the individual or in his progeny in the form of horrible blemishes, deformities or serious brain or nervous disorders. As considerable knowledge of the latter disease exists among all classes of people, its further consideration for the purpose of this paper may be omitted.

The former and more nearly local disorder needs, however, to be considered more at length, because of the fact that it is usually referred to as a more or less insignificant affection and easily curable. This popular notion is reflected in the remark often heard: "It isn't as bad as a severe cold;" and an apparent cure effected occasionally in the course of a few weeks, lends plausibility to this unfortunate delusion. The truth of the matter is, however, that the best experts in the treatment of this disease maintain that really to cure it is one of the most difficult tasks in the domain of medicine and surgery. While a cure often takes place after very persistent treatment, too frequently only the symptoms of the disease abate, while its germs still remain, although they may be so nearly dormant for months or even for years, that their presence is no longer suspected. Should the connubial relation now be assumed, the possible results to the innocent, unsuspecting bride may be read in the following "Story of Rose and Edward," which appeared originally in *The Critic and Guide*, a medical journal, and which has since been going the rounds of other medical publications.

"Miss Rose was a little over twenty-two. She was a bright, cheerful, happy girl—happy not only because on that day she was graduated from Barnard with high honors, but Edward—Dear Ed—whom she loved and looked up to for so many years, had proposed last night; and the passion, romance and aroma of the proposal still lingered with her. . . . And Ed was a husband to be proud of. Though but twenty-eight years old he had already

achieved eminence in the legal profession, and his practice was larger than he could attend to. He was kind-hearted, a gentleman in the noblest sense of the word, and an all-round athlete—a man to protect a woman from every possible care, and make her happy as long as she lived. So thought Rose, and she was right.

“They were married in October. They expected to be away three months on their honeymoon, but they returned after about three weeks. Rose was not feeling well, and traveling and staying in hotels did not agree with her. She looked rather tired and fagged out, but that was natural. It was not natural, however, that after a week’s rest she did not show any improvement. On the contrary, she began to look somewhat haggard. . . . Things continued in this way, getting a little better and a little worse, until the beginning of January. On the fifth of January, she was taken violently and dangerously ill with severe abdominal pain, a very hard and rapid pulse and threatening collapse. Her physician called in a consulting surgeon, and it was decided that in order to save the patient’s life an immediate operation was necessary, and, though it was midnight, the patient was quickly removed to a hospital and operated upon. About three and a half pints of a blood-stained and somewhat purulent serum were removed from her abdomen, and a microscopical examination of this serum demonstrated the presence of tell-tale microbes The operation was a “success,” but—the patient was unsexed.

“A confidential talk with Mr. Edward was held. He searched his memory for a while;—yes, some two years ago he had had a little trouble, . . . but he was all right again in three or four weeks.

“Rose recovered, but you would hardly know her. She aged ten years in ten weeks. She is making no plans, she has no hopes, she is dreaming no dreams—not for the present, at any rate. Never again will she be the happy Rose that she was before she became Mrs. Edward. Never will her home be gladdened by the noise, romp and laughter of little children.

“Who is to blame? Nobody. Rose certainly is not, nor is Ed, for he certainly would have had his right hand cut off—and his left one too—rather than cause the woman he loved above all else in the world any pain or suffering. But he ‘didn’t know’, and we cannot be blamed for the things we do not know, and that we never were told that we ought to know. Should we blame those who insist that all knowledge of sexual matters be kept away from the people? Perhaps; but even they are more to be pitied than blamed;

for they are generally sincere in their beliefs and we cannot blame them for their ignorance."

The awful surgical tragedy just portrayed is, sad to say, duplicated with more or less accuracy somewhere in this country many times every hour of every day of every week in the year.

But retarded and unlooked for troubles due to this disease are not confined to one sex. Years and years after the original infection has taken place—often after middle age—the results of its insidious, destructive processes become manifest in local disturbances accompanied by the keenest annoyances and distress, and resulting frequently in a fatal termination. Such, then, are a few, and only a few, of the physical consequences of unchastity. Surely if it were at all appreciated what unspeakably dreadful risks are taken by indulgence in this sin, even the instinct of self-preservation would guard men and women from falling into its maelstrom. But ignorance on this subject has made them indifferent to its dangers, and they therefore allow themselves to succumb too easily to the imperious promptings of a riotous instinct which should be controlled instead of obeyed.

The fact that this instinct exists and is "natural" is often offered as a physiological excuse for its indulgence. The [truth, however, is that the universal verdict of physiologists and medical men who have made this subject a study is absolutely opposed to this notion. On the contrary, they all agree that this excuse is untenable and that the existence of unchastity has no better physiological reason for its being than it has moral warrant; and the enormity of unchastity from a moral standpoint is universally admitted.

If, then, unchaste living is thoroughly wrong morally; if it is utterly indefensible physiologically; and if, in addition, it offers the greatest physical dangers to which any individual or the race even can be exposed, why should any sane man or woman need to be urged to avoid such a fatuous, fatal folly?

MERCURIAL STOMATITIS.

By D. D. HAGGARD, M. D., Phillipsburg, Kansas.

Stomatitis, or inflammation of the mouth, presents a great variety of forms.

The following are among those most commonly observed:

1. CATARRHAL—Caused by nervous irritation incident to teething, or some Gastro-Intestinal trouble. There is a feverish condition of the mouth with oedema of the tongue and increase of saliva.

2. FOLLICULAR—In this form resicles appear on the tongue, lips or inner side of the cheeks, these soon rupture leaving in those places a small gray ulcer, which makes the ingestion of food a very disagreeable procedure.

3. PARASITIC—This variety, in popular language, called Thrush, is due to the presence of a fungus, *Saccharomyces Albicans*. It appears on the tongue as small grayish spots, which have a tendency to run together and form paths. Sometimes the disease becomes very extensive, involving the entire throat.

4. ARUMATIC—This form as its name would indicate, is the result of wounds or injuries produced by the caustic action of alkalis, acids or other destructive agents.

5. MERCURIAL—This form is caused by the inhalation of mercury vapors, or the absorption or ingestion of mercury in some form.

Some individuals seem to be especially sensitive to the influence of mercury and a very small dose will produce marked physiological action. It is of this latter form that I wish to speak.

DIAGNOSIS.

The diagnosis is usually very simple as the symptoms are characteristic.

The patient usually complains of a metallic taste in the mouth. The teeth convey the impression of soreness, especially when they are brought together as in mastication. The flow of saliva is increased and occasionally the quantity secreted is enormous. The breath becomes very offensive and naturally anorexia is complete. In most cases nervousness is a pronounced symptom.

PROGNOSIS.

The prognosis is usually good, for with appropriate treatment

recovery usually occurs within two or three weeks.

REPORT OF CASE.

On Sept. 5th, I was consulted by a young lady for a slight indisposition. The patient was about five feet tall, and weighed about 130 pounds. She was remarkably developed every way for her age, as she was between fourteen and fifteen years old.

The kidneys were normal. The menses were normal both in quantity and occurrence. There was, however, a history, of occasional constipation.

As preliminary treatment I prescribed ten calomel tablets, in all one grain.

The composition of each tablet follows.

Calomel 1-10; bismuth subnitrate 1-10; sugar of milk q-s-to make 1.grain.

These tablets, ten in number, were to be taken one every half-hour, the last to be followed by 2 heaping teaspoonfuls of effervescing magnesium sulphate in a glass of water.

I was notified, an hour after the salts had been taken, that no bowel action had occurred. I ordered an immediate repetition of the dose of salts. The second dose produced the desired movement.

I heard nothing more from the case until the 8th instant, three days later, when I was requested to call and see the patient on account of her sore mouth. The moment I entered her bed chamber I saw I had a case of Mercurial Stomatitis to deal with. The lips were enormously swollen and were nearly covered with dirty greyish crusts similar to Herpes Facialis or Impetigo. The mouth was held partly open and the swollen gums and enlarged tongue made the diagnosis easy. The teeth were very tender and shutting the mouth increased the discomfort. The breath was offensive, and there was a disagreeable flow of thick saliva, which was very annoying, although not extremely excessive. The gums were soft and gave the impression of recession from the teeth. The appetite was entirely gone, and the patient was extremely nervous, although the temperature and pulse were practically normal.

TREATMENT.

Local applications of ice water were made until the swelling was reduced. Tablets of Potassium Chlorate were administered, being placed on the tongue, with instructions to allow them to dissolve, the patient to swallow the medicated saliva. The bowels

were kept flushed with magnesium salts. Glycerine and cream applied to the crusts softened them and facilitated their removal. In about a week's time the trouble was over, crusts all gone and the patient went about her usual duties.

REMARKS.

I think the reason Ptyolism occurred in this case was that the calomel was not given in sufficient quantity to overcome the constipation and produce a speedy elimination of the mercury. Profiting by this experience I shall ALWAYS PRECEDE the administration of calomel with a thorough flushing of the bowels.

—o—

So great has been the demand that W. B. Saunders Company, the medical publishers of Philadelphia and London, have found it necessary to issue another revised edition of their illustrated catalog of medical and surgical books. In looking through the copy we have received, we find that since the issuance of the last edition six months ago, the publishers have placed on the market some twenty-five new books and new editions—truly an indication of publishing activity. The colored insert plate from Keen's new Surgery, which enhanced the value of the former edition, has been replaced by a new one from the second volume of the same work, and this alone gives the catalogue a real value. A copy will be sent to any physician upon request.

—o—

The Council on Pharmacy and Chemistry report that the following preparations come up to the standard test. The following articles were added to the list: Benzo-Formol Comp., (H. K. Mulford Co.), Blandine Comp. (H. K. Mulford Co.) Cremo-Bismuth, (H. K. Mulford Co.), Methyl-Santal, (H. K. Mulford Co), Protan. (H. K. Mulford Co), Coryfin, (Farbenfabriken of Elberfeld Co), Monotal (Farbenfabriken of Elberfeld Co.), Novaspirin, (Farbenfabriken of Elberfeld Co.)

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— O —

G. Frank Lydston (Med. Rec., September 14, 1907), gives an account of three cases in which typhoid fever complicated surgical conditions to illustrate the point that we must always be on the lookout for this disease in the course of surgical cases.

ABSTRACTS.

Life Insurance Examination Fees.

Your committee appointed to prepare resolutions on the question of a suitable fee for insurance examinations of old line companies," respectfully submits the following report:

I. The fee to be asked for an examination for a life insurance company should be determined by the same rules that decide the value of our services to private patients.

It is impossible, consequently, to state any sum as a binding or authoritative fee, since physicians place different prices on the value of their services. It might be remarked in passing, that those physicians who habitually value their service at a lower price than is ordinarily charged by their neighbors, are receiving all that their services are worth with a possibility of being overpaid. All that can be offered in a report of this kind is an estimate of a fair, minimum fee for the self-respecting physician of average standing. Such a man will adhere to a fair fee, regardless of the "cut rate" fees by others even at the risk of personal financial loss. His dignity as a gentleman, the honor of his profession, the debt he owes to it, and the regard of right living (more valuable and satisfying than any money gain) all demand this. Your committee will not urge the adoption of its conclusions, as a combination to maintain "rates", but their acceptance by each one individually, as far as it appears right to each individual, because it is right, oblivious of the conclusion of any one else.

II. In determining the value of the services included in a life insurance examination, we must keep in mind:—

1. That an examination which partakes of some of the features of a consultation, commands a relatively higher price than the same examination for the exclusive use of the examiner.

2. That an examination plus a written report with an opinion, is worth more than an identical examination without a written report, with a verbal opinion to the patient alone.

3. That a physician is justified in charging a larger fee for an examination where he is only to give an opinion than where the examination is to be followed by a series of fees in the course of treatment.

III. Keeping these propositions in mind, let us try to make out a bill of items:—

Should a patient call at the office of any of our number and re-

quire, for the proper understanding of his condition, an examination such as is usually included in the routine life examination, few, if any, of us would ask less than one dollar for the service rendered; most of us would ask more. Then, if an urinalysis were required, an additional dollar would be demanded. Should the patient at the start have told you that he was asking for this examination only to learn his physical condition and that he did not purpose to put himself under your professional care, we doubt if many, unless under some stress, would not raise the fee they had proposed to ask by fifty cents or even a dollar more. If, in addition, you were asked to write a full report of your findings, detailing with some minuteness the conditions of the various organs, which report is to be used by Dr. X. to assist him in giving an opinion for which he is to be paid, should you double the amount thought of for a fee, it would not be excessive. Indeed, were your patient ordinarily well to do, most of you, when asked the amount of your fee for performing such service, would quietly say "ten dollars" and the fee be cheerfully paid and thought to be a reasonable one.

IV. If through custom or the result of conference a minimum fee prevails in any region, the only valid reasons for diminishing the amount are that the particular examination in hand (1) requires less skill; (2) takes less time; (3) involves smaller responsibility, or (4) the financial condition of the patient demands a concession.

If none of these elements be present, ordinary decency demands that we maintain the fee. Not that we are bound by any pledge, but, if a man has any conceit of himself, he ought to value his services to be worth as much as those of his neighbor; and, if he has any respect for his profession, he will uphold her dignity and not engage in a custom that is off color even in the commercial world. He will not "cut prices."

V. Certain life insurance companies accepted the idea that five dollars was a proper fee for an examination of an applicant for insurance in their companies. Now they have notified their medical examiners of a reduction in the fee to be paid for a number, probably the majority, of the examinations. We have seen above that five dollars is a very moderate fee for the service rendered. Do the companies reducing their fees claim any of the reasons already quoted as a reason why this reduction should be accepted by the physicians? The new examinations will require as much time, exact as much skill, and demand as much responsibility as they

formerly did. Their only reason can be the financial one. Is this a valid reason?

VI. Because of abuses in the conduct of life insurance companies, there has been new legislation and the companies are limited in the amount of their expenditures. Because of this legal restriction, the companies ask their medical advisers to reduce their fees. In order that there be no misrepresentation on the part of your committee in the presentation of this claim, we quote from a letter of a president of one of the companies reducing their medical examination fees. It was sent to one of the [examiners of the company in defense of the action of the company:

"It appears, from articles which I have seen in certain medical journals and from the action of some medical societies, that the physicians of the country are not aware of the causes which led to the change in the medical fees allowed by the ----- and by other companies. This change has been necessitated by the new legislation, and it seems to me advisable to explain to you the requirements of this law in some detail. The section to which I refer reads as follows:—

"Section 97. Limitation of Expenses. No domestic life insurance corporation shall in any calendar year after the year nineteen hundred and six spend or become liable for or permit any persons, firm or corporation to expend on its behalf or under any agreement with it (1) for commissions on first years premium, (2) for compensation, not paid by commission, for services in obtaining new insurance exclusive of salaries paid in good faith for agency supervision either at the home office or at branch office, (3) for medical examinations of proposed risks, and (4) for advances to agents, an amount exceeding in the aggregate the total loadings upon the premiums for the first year of insurance received in said calendar year (calculated on the basis of the American experience table of mortality with interest at the rate of three and one half per centum per annum) and the present values of the assumed mortality gains for the first five years of insurance on the policies on which the first premium, or installment thereof, has been received during said calendar year, as ascertained by the select and ultimate method of valuation as provided in Section eighty-four of this chapter."

In brief, this Section means that the four items referred to are directly chargeable against new business, and that the companies are not allowed to spend in total for these four items an amount in excess of the actual margin of loadings on the new premiums paid plus the mortality gain. This law will, in any event, necessitate a very great reduction in commissions paid to agents, and I think it will be extremely difficult to retain in our employ many of the men who have been working for us in the past. The agent is the one who will feel most particularly this reduction."

We interrupt the quotation to call your attention to the reasoning employed. Certain abuses crept into the management of the life insurance companies, among others, excessive commissions to agents. The legislature, in its efforts to prevent the recurrence or continuance of these abuses, limits the amount of expenditures. This will reduce the amount of the commissions paid to agents to such a degree that the company fears it will not be able to retain the agents heretofore overpaid. That it may be able to make as small a reduction as possible, it proposes to reduce the fee of the medical examiner, which was not thought to have been too large, thus taxing him to assist in the soliciting of business. It is possible to explain this method of procedure only on the supposition that the doctors, or some of them, are always willing to accept any old thing that may be offered to them. Resuming our quotation:—

“In the case of policies of any material size, say \$3000 or over, there will be margin enough to provide for the old medical fee of \$5.00; but on smaller policies, inasmuch as the medical fee has not under the old schedule borne any relation to the size of the premium collected, there is a very small margin left for the agent after paying the old fee and the cost of inspection.

The following table will explain my meaning:

ORDINARY LIFE				
Loading and Balance				
Age	Prem	Mortality Gain	for Agent	Per Cent
25	20 84	15.55	9.35	45
30	23.72	16.59	10.59	45
40	32 43	20.62	14 62	45
TWENTY-YEAR ENDOWMENT				
25	49.45	19.40	13.40	27
30	50.28	20 27	14.27	28
40	53.46	23.49	17.49	33

This balance for agent in column four is after paying \$5.00 medical fee and the cost of inspection.

You will see from this table (which is only approximate and in which table the possible commission which we will be able to pay the agent is probably in excess of what we can actually pay) that the percentage which a \$5.00 medical fee bears to the figures in the column headed “Loading and Mortality Gain” is excessive, and that the change which we have made was really forced upon us by the law; e. g., a medical fee of \$5.00 on an ordinary life policy for \$1000 would absorb one-third of the entire figure which the company under this law is allowed to expend in securing this business. If the same ordinary life policy were for \$3000, the loading and

mortality gain would be \$45.00 and the medical fee still the same; viz, \$5.00, or one-ninth of the amount allowed to the company for expenditure.

I think if you will examine the underlying principle of this law, and will study the above table, you will see the necessity and the justice of the position we have taken."

We do not wish to discuss the arguments of this letter at length, but since the company of which the writer of the above letter is the president offers a three dollar fee for an examination when the policy is for \$1000, it is fair to infer that it does not consider that the physician is receiving an excessive fee should he be given twenty per cent of the sum permitted by the law to be expended. Would it not be simple justice, just ordinary business honesty, without any sentiment mingled with it) if the fee is to be added to the amount of the policy, that when the amount of the policy amounts to \$3000, the fee should be in the same ratio, or \$9.00, not the \$5.00 which the company offers. And, although the figures are kept from us in this letter, if the increase at all corresponds as the amount of the policy increases, what can we say of the princely munificence or reckless extravagance of offering a fee of \$7.50 for the examination when the policy is for \$15,000?

Neither will it be wise for your committee to enter into a discussion upon the proper amounts to be paid to agents for securing business, since we are not acquainted with all the facts. We will only call your attention to the following: (1) The legislative committee that framed the act was aware of the amount paid for the examinations and thought the sum left after such payment had been made to be ample for the compensation of the agents. (2) The letter clearly shows that the insurance companies dread the loss of agents by the reduction of the fees, although they had been receiving excessive commissions; while they expect the physician to accept mildly anything that may be offered to him. In this they but reason the almost uniform action of the profession for a period indefinitely long in the past, which has resulted in the uniform belittling of the value of the services of the physician when rendered to the public or to corporations.

But, after all, is there any reason in all this for accepting a three dollar fee? Does not the physician give as much for the \$1000 application as for one for \$3000 or \$10,000? If the agent be required to take an insufficient fee for securing a thousand dollar application, that will be an incentive to him to secure the issuing of

policies for larger amounts. Of the reasons given, justifying the reduction of a fee, we have seen that the only one that applies to the question under discussion is the poverty of the patient,—in this instance the insurance company. Do you think these corporations fit objects on whom to bestow your charity?

Wherefor your committee sees no valid reasons for accepting the reduction of the fee.

VII. The discussion, thus far, has related to those companies which have been paying five dollars and now wish to reduce it. There are companies that never paid over three dollars and have found no difficulty in securing examiners. Your committee can see no reason why these companies should not be asked to advance their fees. If our contention is true, that five dollars is less than we would be apt to ask an individual for the same service, we ought to demand this as a minimum fee for any full life insurance examination, and let the company find whom they can if they are not willing to pay it.

We would note that the acceptance of such a fee works harm to the profession at large. Your committee quotes from another letter, this time from a medical director of one of the companies that were forced to show their extravagant expenditures in certain directions, under the skillful questioning of Governor Hughes. It might be remarked, in passing, that the examination did not reveal the amount of the salaries of the medical directors, although the question was asked definitely, nor does a careful search of the records at the Insurance Department at Albany furnish the information.

Your favor of the 18th instant is at hand. I shall have to enter a protest against one statement in it. Judging by the standard which physicians themselves have set, \$3.00 is an adequate fee for the service we require. Our former payment, therefore, of \$500 was an extravagance. Out of 298 insurance organizations in the United States only nineteen have a flat fee of \$5.00, of the others eleven have a graduated schedule similar to ours, and the remaining 268 have a flat fee of three dollars or less.

This, remember, is from a medical man, one of those whom rumor saith receives anywhere from \$25.00 to \$50.00 for each and every hour spent in the office of the company, whose salaries are so large that the officials of the company did not know their amount when the affairs of the company were under official investigation. It is such a one that says the payment of "\$5.000 was an extravagance." But, after all, the sting in his letter lies in the

fact that physicians are found who will take whatever they get regardless of the true value of the service, and of its effects upon the profession at large. We can not but think that much of this is done through thoughtlessness.

VIII. This report does not touch the various forms of industrial insurance. There are other factors entering into that department of insurance which require a separate consideration, and the introduction of it here would fog the main issue.

We believe that we have stated correctly the principles involved in determining the proper fee to ask for a life insurance examination. We, therefore, recommend the adoption of the following:—

Resolved, That the Medical Society of Northampton County affirms, as an abstract proposition, that five dollars is as small a fee as should be charged for a full, regular examination for a life insurance company.

Resolved, That the physicians in this county be asked to live up to this abstract proposition in their practice, and to decline to make an examination for less. Not because it is a concert of action on the part of the physicians, but because it is the right thing to do.

Resolved, That a copy of this report be sent to every physician in the county, with the request that free and candid comments be made upon it, and that the committee be continued to receive and report on these replies.

Resolved, That the necessary expenses for printing, postage and clerical assistance in sending out this report be paid by the society after the bill has been approved upon its presentation in the open meeting of the society.

CHARLES M'INTIRE.
W. P. WALKER.

NEWS AND NOTES.

The New Municipal Kansas City Hospital.

It will be remembered that Thomas Swope gave the ground for this new hospital, which is located on the high ground a few blocks from the site of the new union depot. The Kansas City Times has this to say about the new building:

"The new general hospital will not be finished until next spring. Because it wants to learn how much money is available, the board of public works decided yesterday to postpone the awarding of contracts for interior furnishings.

The board believes the hospital will be ready for occupancy April 1. It will cost about \$108,000. The bond issue for the hospital was \$225,000. The \$108,000 includes the purchase of the Norton site, a small piece of ground on the north side of the hospital grounds. The condemnation proceedings for this piece of ground is pending in the Missouri supreme court on an appeal to test the right of the board of public works to condemn land for public purposes. The hospital has deposited \$8,000 to pay for this land when the appeal is decided. It is estimated that the cost of the interior finishings will be about \$6,800. The contracts for glass, cement floors, painting and plumbing connections will probably be awarded next Tuesday.

"The bond issue of \$225,000 voted for the erection of the hospital was spent by the board in erecting the building," P. S. Brown, Jr., a member of the board said yesterday. "Details of the exterior and interior finishing have been provided for by special appropriations from the city council. Aside from the new Philadelphia general hospital now building, the Kansas City hospital will be the best structure of its kind in the West. Its ward capacity is to be three times that of the present building at Twenty-second and Cherry streets. It has been estimated by the architects that there will be a capacity for over six hundred patients in the new hospital."

The board has not decided what it will do with the old hospital grounds and buildings when they are abandoned. Dr. St. Elmo Sanders, city physician, has suggested that the grounds be converted into a hospital park."

The Phoenix Mutual Life Insurance Co. is another one of the Old Line Insurance companies who has raised the examination fee to five dollars.

Here is an Opportunity for Someone.

The following advertisement is clipped from the "want" column of the Kansas City Times. Are these "case-taking doctors" operating in your town? If they have not arrived yet, an ounce of prevention might be worth a pound of cure.

CASE-TAKING DOCTORS TO TRAVEL.
Medical Institute 1110 N. 6th, Kansas
City, Kan.

At least it would be well for every reader to note the name and address of this institution—for future reference.

SPECIAL ANNOUNCEMENT

OF THE

Advance in the Requirements for Admission to the School of Medicine.

From the beginning of the University, the establishment of a medical school has been contemplated when the conditions were such that it could be done on the same thorough basis that had characterized the foundation of the other schools of the institution. In pursuance of this plan, the medical work of the first two years was organized and put upon a definite basis in 1899. As Lawrence did not furnish sufficient clinical or hospital facilities for the last two years, this was postponed until a suitable opportunity offered itself. This occurred when Dr. Simeon B. Bell, of Rosedale, Kansas, gave the University money and property sufficient to build and equip the necessary laboratories and hospitals, and, by the merging in the University of the Kansas City Medical College, the Medico-chirurgical College, and the College of Physicians and Surgeons of Kansas City, making it possible to give the full four-year course for the first time in the college year of 1905-'06.

In the meanwhile the work of the first two years has gradually grown since 1899, in conformity with the advances that medical education is making in this country. The laboratory equipment and library facilities have been increased as fast as the funds became available for such a purpose, until at this time the work is well established and the equipment such that the work can be satisfactorily given.

The new buildings at Rosedale are built to conform with the most advanced requirements of medical instruction. Special laboratories and facilities have been provided for investigation along various lines of medical work, so that it is now felt that the medical instruction given here compares favorably with the other schools of the University and the older medical schools of the country.

In this growth it has been found that, here as elsewhere, this increase in the complexity of the medical course demands an increase in the ability of the student to grasp facts as they are presented to him even from the first. It also requires the more or less complete elimination of certain subjects from the regular medical course.

This advance in medical education has been almost entirely along the lines of more laboratory work and work of greater exactness, while

from the standpoint of instruction it means fewer and fewer lectures and more and more individual instruction and individual effort on the part of the student.

It is realized more and more that, in order to give an effective medical education, the student must have a thorough grounding in the various subjects covered by the general terms of anatomy, physiology, and pathology. These subjects are taught almost entirely in laboratories and by laboratory methods, and, for the student who has never been taught to use his hands and powers of observation, this is so new to him that it is almost the end of the first year before he begins to comprehend what is offered to him.

The student who has had but a high-school education finds the great mass of medical literature in German and French closed to him, and when it is considered how very valuable this is, due to the fostering of laboratories and libraries that are used for research by the governments of those countries, it means a very great loss to him.

The public and the profession, as the country grows older and medical knowledge increases, are both demanding more knowledge and a wider information on the part of the physician. The physician of the future must be a man who is able to do more than treat diseases. He must understand the underlying principles of his profession and be ready to serve the community in which he lives, and perhaps it will be his privilege to serve it most efficiently through that greatest and most actively growing field of applied biological science, viz., preventive medicine.

In recognition of these demands, the officials of the University have decided to raise the requirements for entrance to the medical school to one year of approved college work in September, 1908, and probably will soon increase them to two years of approved college work.

With the requirements thus raised, it will be possible for every student to obtain the bachelor's degree at the end of the first two years of medicine, as is now arranged for in the combined college and medical course, requiring six years for completion. This preliminary college work should be so arranged as to give the broadest bearing on the studies which are to follow in the medical school, i. e., subjects which will enable the prospective student of medicine to work effectively.

These two years of college work should include the following studies, with more or less modification to suit individual needs and the institution in which the student is taking this preliminary course: Two years of work in chemistry, with laboratory work, covering inorganic and organic chemistry well. One year of work in physics, with laboratory work, if possible. At least one year of biology, with laboratory work. This should be zoology or comparative anatomy, if it is possible to devote

KANSAS MEDICAL SOCIETY.

but one year to it. All of the English, French and German that the student can obtain. In fact, it is felt that this side of his preparation is of but little less importance than the work in science.

The Dean of the scientific department will be glad to discuss and advise prospective medical students as to their preliminary work, and in this way provide for its being arranged so that the student will be best equipped to do effective work upon his entering the Medical School.

A REQUEST—The physicians of the state, through their interest in medical education, have aided largely in the establishment of a Kansas School of Medicine at the State University. This is now well under way and prospering steadily. Indeed, so large are the classes that some effort is necessary to supply them with dissecting material. This suggests a way in which physicians may send further aid to the School, as many have in part, i. e., by urging the local undertakers to send unclaimed bodies to the School.

In teaching anatomy, one of the most difficult things is to secure early stages in the development of the human body, which are of great interest and invaluable for anatomical and histological research. It is only through the interest and co-operation of many practitioners that a proper teaching collection of this kind can be built up. It is the ambition of the teachers at the State University to give the young people that come to them the largest possible opportunity in the study of medicine. Accordingly, they make an urgent appeal to physicians to send to the embryological laboratory such embryos and early foetuses as may come into their hands. These may be preserved in ten per cent. formalin, a saturated aqueous solution of corrosive sublimate, or thirty-per-cent. alcohol, and shipped by express to the University of Kansas, care of C. E. McClung. To secure proper preservation of material, it should be placed in the fixing fluid as quickly as possible and shipped to the laboratory. It is especially desired to secure embryos of the first month for sectioning, and in order to insure thorough fixation of these the chorion, or outer membrane, should be punctured, care being taken to avoid injury to the embryo. The department will be glad to meet any expenses incurred for preservation or express charges.

University of Kansas

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Lawrence. Kan.

BOOK REVIEW.

Dyspnoea and Cyanosis.—The first of a series of monographs by Prof. Dr. Edmund von Neusser of Vienna. Translated by Dr. Andrew McFarlane of Albany, N. Y. Octavo, cloth, pp 204, New York, E. B. Treat & Co. (241-243 West 23d street) 1907. Price \$1 50.

In the translators preface we read the following:

The development of bacteriology, since Koch's discovery of the tubercle bacillus in 1881 and the application of solid culture media for the differential growth of bacteria have tended in the last two decades to lead the physician to rely for his diagnosis upon laboratory aids and less upon clinical observation. In order to be thoroughly understood and rationally treated, disease must be studied primarily in its entirety as a pathological process. The physician cannot absolve himself from this responsibility nor find any easy road through the work of another to this desired goal.

The all-absorbing search for the specific cause of a disease, although most valuable when indicated, has too often pushed into the background the manifest clinical evidences of the disease, and the physician has regarded them of subordinate value and apparently even of negligible worth.

The diagnosis of disease must, in the great majority of patients, be determined at the bed-side and not in the laboratory. Laboratory findings are most valuable aids to diagnoses but are not, except in a few instances, diagnoses themselves and never substitutes for clinical bed-side work.

This present series of monographs accentuates the value of the study of symptoms as observed at the bed-side of the patient and reproduces the marvelous clinical pictures of Trousseau, Niemeyer, Sydenham, Flint and others, illuminated by present-day knowledge of pathology and clinical methods.

Prof. Edmund Neusser, with his rare diagnostic instinct and his almost uncanny memory of clinical facts and their correlation to pathological findings, typifies in the strict sense the modern master clinician.

These lectures are the resultant of almost limitless clinical material and of a scientific acumen which does not overlook any fact no matter how seemingly trivial and unimportant."

It is true that we do need some master of the art of observing to give us a review of the occurrences and possible causation of the more important clinical symptoms, because the latest books on diagnosis have been written rather from the standpoint of organology and pathological anatomy than from that of the bedside observer. However, the booklet before us is so terse and concise that it is difficult reading. It will not appeal to the average man as such a book should appeal, nor as this book must appeal to the abstruse thinking of a philosopher. It requires more than encyclopedia information to make such a work successful.

Surgery, Its Principles and Practice.—Edited by W. W. Keen, M. D., L.

L. D., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College. Published by Saunders & Co., in five volumes. Cloth \$7, half morocco \$8 per volume. Volume 11 has 920 pages, 572 illustrations and 9 colored plates.

The chapter on diseases of the Bones and Pathology of the chapter on the Surgery of the Joints is contributed by E. H. Nichols, assistant professor of Surgical Pathology at Harvard. The clinical part of the chapter on the Surgery of the Joints is contributed by another Harvard man R. W. Lovett, instructor in Orthopedic Surgery, who also supplies a chapter on Orthopedic Surgery.

D. N. Eisendrath, adjunct professor of Surgery in the University of Illinois, writes two excellent chapters devoted to Fracture and Dislocations.

Only one chapter is given to the Surgery of the Muscles, Tendons and Bursae, but the subject is well taken care of. J. F. Binnie, professor of Surgery of the University of Kansas, writes it.

The Surgery of the Lymphatic System is written by F. H. Gerrish, professor of Surgery in Bowdoin college who gives—pages to the subject.

The Surgery of the Skin is well taken care of by J. A. Fordyce, professor of Dermatology and Syphillogy in the University and Bellevue Hospital Medical Colleges.

The Pathology of the chief Surgical Disorders of the Nervous System is discussed by W. G. Spiller, professor of Neuropathology in the University of Pennsylvania; the Surgery of the Nerves and Spine, by George Woolsey, professor of Anatomy and Clinical Surgery in Cornell; Traumatic Neurasthenia, Hysteria and Insanity, by F. X. Dercum, professor of Nervous and Mental Diseases in Jefferson Medical college; and Surgery of the Insane and Surgery of insanity by J. C. DaCosta, professor of Principles and of Clinical surgery of Jefferson Medical college.

It is of interest to Kansans that one of the most important chapters is written by Professor Binnie of the medical department of our university, who handles the subject in a thorough and definite manner. It is to be noted that the Lymphatic System comes in for a discussion from a surgical standpoint—something that we general practitioners have been looking for for a long time. Again in the treatment of the nervous system from a surgical standpoint, which occupies the last five chapters, find something new and in keeping with the rapid development of the last few years along this line. And the information one gets is clear, definite and practical.

These chapters will certainly interest that part of the profession especially, who are engaged in the state hospitals for the insane. The chapter on fractures occupies only 200 pages, but the information is so concise and definite that the rare and unusual conditions are considered and the common ones not neglected in the least. Not the least valuable part of this chapter is the clear exposition of the very latest and best methods of treatment.

Throughout the whole book the space allotted to pathology and diagnosis is proportioned to treatment in accordance to their relative importance to the practitioner. Altogether this volume keeps up the promise held out by the first of giving the profession the very latest and best surgical information.

Diagnosis and Treatment of Diseases of Women.—By H. S. Crossen, M. D., Clinical Professor of Gynecology, Washington University, Saint Louis, Mo. Published by the C. V. Mosby Book and Publishing Co.

This volume is printed on excellent paper and bound in scarlet and gilt cloth. There are 800 pages and 700 illustrations, 480 of which are from other texts on the subject. The subject matter is presented in a rhetorical style so that one cannot miss the important points presented. Most space is devoted to the diagnosis and treatment of gynecological diseases with only enough of the etiology and pathology to establish the diagnosis. For one who prefers illustrations to solid printed text this book will fill the bill.

SOCIETY NOTES.

Decatur and Norton County Medical Society. You are earnestly requested to be present. Dr Cole's office; 2:30 p. m., December 10, 1907.

PROGRAM.

- 1—Annual election of officers.
- 2—President's address, C. W. Cole.
Paper, C. G. Brethouwer.
- 3—Cholecystitis Surgically Considered, H. O. Hardesty.
- 4—Clinic, General.

Bring in at least one interesting case. A general discussion will follow each paper.

- 5—Social evening session.

You are expected to be present, and a profitable time is assured.

C. W. Cole, President.

C. S. Kenney, Secretary.

SOCIETY REPORTS.

Hutchinson, Kansas, November 25, 1907.

Editor Journal:—The Reno County Medical Society held its regular monthly meeting in the Commercial club rooms Friday evening, November 22, 1907. There was a good attendance. Dr. F. H. Rose of Stafford and Dr. W. F. Schoor of Hutchinson, were on the program for papers, after which a number of clinical cases were presented and a lively discussion followed, bringing out many interesting and important points in obscure cases.

At the October meeting Dr. C. A. Mann presented a paper on Acute Infectious, Cerebro-Spinal Meningitis. A timely subject which started every member to thinking. At Friday's meeting the members of the society voted unanimously to take up a post graduate course for county societies, every one realizing the benefit derived from harmonious action with frequent and free discussions of important cases.

William F. Schoor, Secretary.

The H. M. C. Compound Anesthetic.

By J. W. NEPTUNE, Salina, Kan.

Men who, like myself, are engaged in the arduous labors of the general practitioner, rarely have time to sit down and prepare papers for medical journals, to which we can give the research necessary to fit them for a place in the polished medical periodicals of the day. Sometimes, however, there comes before us the question, whether there is the need, not for productions which require an unlimited medical library which will enable us to present a complete monograph on the subject, but where the daily experience of each clinical observer serves to elucidate a point in practice which can only be decided in such a manner.

I, therefore, feel it incumbent upon me to contribute my own clinical observations upon a remedy which seems lately to be exciting a good deal of attention, that is, the H-M-C Compound anesthetic. This remedy has been opposed with unexampled virulence in certain quarters, but seems to be establishing itself in the affections of the profession, since whenever I have attended a meeting of physicians recently there have been some at least who have a word to give in its praise. Having no earthly interest either in favoring it or opposing it, I relate my own experience in its clinical application:

My use of this remedy has been largely in the line of obstetrics.

It has seemed to me to be indicated especially in the first stage of labor, when the os uteri is not yet open, but is somewhat rigid, and the patient is in danger of exhausting herself by efforts to bear down, under circumstances that can only result in her exhausting herself before the time comes when such efforts could be of any avail. Under these circumstances I have been giving of the full strength of H-M-C- compound tablets; and in a few minutes, when the patient has been relieved of the suffering and shows a disposition to sleep between the pains, I usually take my departure, if case is in town, or near my office, feeling quite safe in absenting myself for two or three hours. This one dose is generally sufficient to take the patient through the first stage and up to the beginning of the second; and usually this is the only dose of the tablet which I employ.

About the beginning of the second stage, when the expulsive pains commence, I usually give a little chloroform, generally a mere whiff, just enough to ease the pains and render them bearable. Sometimes the patient is not under its influence more than two to five minutes. To the use of chloroform at this time I attribute my success in preserving the perineum.

I have never noticed any bad effects on the mother from the H-M-C. On one occasion only the child showed cyanosis, recovering after we had worked over it about ten minutes. But this was not more in degree than I have noticed when the H-M-C anesthetic was not used. I have not noticed any special symptoms in the child that could be attributed to the H-M-C. If any prolongation of the labor is to be attributed to the use of this anesthetic, it cannot but be very slight; in fact I cannot say that I have noticed any at all; although possibly when my experience with the anesthetic has extended over several hundred cases I may be able to deduce, as Gauss has said, a little prolongation, about one hour in all. The loss of blood seems to be distinctly reduced. There are no after-pains; the period subsequent to the birth of the child during which these are most likely to occur, being occupied by the patient in a natural and restorative slumber.

I have now used the H-M-C in twenty obstetric cases, and while this number is small I have carefully observed the action of the anesthetic during them, and am satisfied that my conclusions as above recorded are correct.

I have also administered this anesthetic in about half a dozen surgical operations, which have been uniformly favorable. As yet no perilous symptoms or even unpleasant ones have been manifested in any of these cases. I submit this simply as a small personal contribution on this most interesting topic.

COMMUNICATION.

(Resolutions adopted by the Executive Committee of the American National Red Cross, October 18, 1907.)

Whereas, By international agreement in the Treaty of Geneva, 1864, and the revised Treaty of Geneva, 1906, "the emblem of the Red Cross on a white ground and the words Red Cross or Geneva Cross" were adopted to designate the personnel protected by this convention, and

Whereas, The Treaty further provides (Article 23) that "the emblem of the Red Cross on a white ground and the words Red Cross or Geneva Cross can only be used whether in time of peace or war, to protect or designate sanitary formations and establishments, the personnel and material protected by this convention," and

Whereas, The American National Red Cross comes under the regulations of this Treaty, according to Article 10, "Volunteer aid societies, duly recognized and authorized by their respective governments," such recognition and authority having been conferred upon the American National Red Cross in the Charter granted by Congress, January 5, 1905, Sec. 2, "The corporation hereby created is designated as the organization which is authorized to act in matters of relief under said Treaty," and, furthermore,

Whereas, In the Revised Treaty of Geneva, 1906, in Article 27, it is provided that "the signatory powers whose legislation should not now be adequate, engage to take or recommend to their legislatures such measures as may be necessary to prevent the use by private persons or by societies other than those upon which this convention confers the right thereto of the emblem or name of the Red Cross or Geneva Cross."

Be it Resolved, That the Executive Committee of the American National Red Cross requests that all hospitals, health departments and like institutions kindly desist from the use of the Red Cross created for the special purpose mentioned above, and suggests that for it should be substituted some other insignia, such as a green St. Andrew's Cross on a white ground, to be named the "Hospital Cross," and used to designate all hospitals (save such as are under the Medical Departments of the Army and Navy and the authorized volunteer aid society of the government), all health departments and like institutions, and, further

Be it Resolved, That the Executive Committee of the Amer-

ican National Red Cross likewise requests that all individuals or business firms and corporations who employ the Geneva Red Cross for business purposes, kindly desist from such use, gradually withdrawing its employment and substituting some other distinguishing mark.

—o—

The Serum Treatment of Exophthalmic Goitre.

Harriet C. B. Alexander * discusses the subject and reports thirteen cases. Four principal theories of the disease have been advanced: (1) That it is due to disease of the sympathetic nervous system; (2) that the seat of the malady is the medulla oblongata; (3) that it is primarily a disease of the thyroid gland; and (4) that it is a neurosis.

Modern therapeutic measures have been largely based on the "thyroid" theory. The results of partial strumectomy indicates that the successful removal of a portion of the thyroid gland can lead to cure or to definite amelioration of the condition. On the theory that the hyreoid secretion normally neutralizes certain general metabolic poisons in the body, Moebius and others conceived of treating cases of exophthalmic goitre, in which there is presumably an excess of thyroid secretion in the body, by introducing subcutaneously, or by the mouth, the serum of hyreoidcomized animals. It was hoped that the non-neutralized general metabolic poisons of such animals would nullify the toxic effect of the excessive hyreoid secretion. As to the treatment, experience has shown the great importance of general measures; complete rest for a time, fresh air, careful diet, mild balneotherapy, etc.

The name Thyreoidectin has been given to a preparation obtained under aseptic precautions from the blood of animals from which the thyroid glands have been removed, and which is exhibited as a redish brown powder contained in capsules, usually five grains each. Carefully conducted clinical trials seem to show that Thyreoidectin can be depended upon to control the characteristic symptoms of exophthalmic goitre. In most cases the patient experiences much relief from the restlessness, tremors, insomnia and other nervous symptoms so frequently present, and a gradual lessening of the frequency of the pulse rate, decrease in the size of the glands, and a diminution of the exophthalmos, with an increase of weight and a much better condition generally. The dose of Thyreoidectin seems to be one or more capsules after each meal, according to the judgment of the physician and the reaction of the patient.

In nine of the author's thirteen cases the size of the gland was materially reduced, and in every case improvement was observed with respect to one or more of the symptoms.

*The American Practitioner and News, August, 1907.

Report of Communication on Arrangements for International Congress on Tuberculosis.

Washington, Nov. 2, 1907.

Progress along all lines connected with the International Congress on Tuberculosis, which is to take place in Washington September 21 to October 12, 1908, was shown by the reports presented at a meeting of the committee of arrangements, held in New York, at the Associated Charities Building, Monday evening, Oct. 28. Dr. Lawrence F. Flick of Philadelphia, chairman of the committee presided, and the other members present were Dr. Joseph Walsh, Philadelphia, secretary; Dr. John S. Fulton, Washington, secretary-general; Mr. William H. Baldwin, Washington, Dr. Herman M. Biggs, New York, Dr. Frank Billings, Chicago, Mr. Edward T. Devine, New York, Mr. Livingston Farrand, New York, Dr. J. C. Greenway, Greenwich, Conn., Dr. Chas. J. Hatfield, Philadelphia, Dr. Abraham Jacobi, New York, Dr. Alfred Meyer, Mrs. James E. Newcomb, New York, Gen. Geo. M. Sternberg, Washington, and Dr. Wm. H. Welch, Baltimore.

The meeting was the first held since Dr. Flick's return from abroad, and his reports of his visits to the International Conference on Tuberculosis in Vienna and to the International Congress on Hygiene and Demography, at Berlin, were interesting features of the session. More than a thousand delegates were registered at Vienna, he said, and the gathering at Berlin was quite as large. The leading men in both associations are looking forward with a great deal of enthusiasm, Dr. Flick said, to the meeting in Washington, next year, and about four hundred of the members of the foreign organizations may be expected to attend the congress. The conference selected this country as its place of meeting in 1908, just as the congress did two years ago. The conference and the congress are two distinct organizations. The international conference on Tuberculosis meets every year and keeps up a continuous organization with headquarters in Berlin. The International Congress on Tuberculosis meets only once in three years and does not maintain an international bureau in the intervals. Dr. Flick stated that at the International Conference, interest centered especially in the time-worn subject of the routes of invasion for the tubercle bacillus. It seems to have been demonstrated that the disease may be contracted by both the respiratory route, and the alimentary route.

Though this does not make us much wiser in a practical way, still it is somewhat comforting to know that the respiratory route is less important than it was once thought to be. On the other hand that information is compensated by the importance of the alimentary route.

In connection with this account of the progress made in the preliminary arrangements for the International Congress on Tuberculosis Dr. John S. Fulton the secretary-general, reported that ten distinguished foreigners have consented to participate in the series of special addresses that are to form a part of the program. The names of these eminent specialists follow:— Dr. R. W. Philip, Edinburgh; Dr. C. Theodore Williams, London; Dr. Arthur News-holme, health officer, Brighton, England; Dr. C. H. Spronck, Utrecht, Holland; Dr. Karl Turban Davos-Platz, Switzerland; Dr. Gotthold Pannwitz, Charlottenburg; Dr. Emil von Behring, Marburg; Dr. A. Calmette, Pasteur Institute, Lisle, France; Dr. Maurice Letulle, Paris; and Dr. S. Kitasato, Tokyo, Japan.

Dr. Fulton also reported that up to the date of the meeting, the governors of twenty-three states had lent official auspices to the congress. This not only assures official representation so far as that many states are concerned, but it insures an active organization in each of these states, that will be interested in the congress. The states in which this action has been taken so far, are: California, Kansas, Utah, Tennessee, Montana, South Carolina, North Dakota, North Carolina, Minnesota, Maryland, Wisconsin, New York, Illinois, Massachusetts, Iowa, Vermont, Indiana, Maine, Michigan, West Virginia, Ohio, Missouri, Kentucky.

Reporting on the formation of state committees, the secretary-general said that such committees had been appointed in nearly all of the states in the United States; that several have already organized and are earnestly at work. He reported also that replies have been received from various foreign countries in reference to the appointment of committees, and the replies indicate that the countries addressed will be represented in nearly every instance by exhibits as well as by delegates.

The School and the Street.

From the Medical Review of Reviews.

The day when absolute possession of scientific and technical knowledge was a prerogative of the fraternity of professional men has been relegated to the domain of historical record.

The popularization of such knowledge is the natural sequence of a vast increase in the comprehension of higher education and the universal dissemination of facts through the agency of periodical literature. The school has been supplied with every available means for scientific research and is the great laboratory in which every public need is carefully studied and the results adopted to social requirements. It is a significant fact, however, that the man in the street has, by his financial assistance, cleared the way for the propagation of scholastic attainment far exceeding the possibilities of a quarter of a century ago.

The school has made enormous progress during that period, but the street has advanced even more rapidly.

The progress of medical science has been such as to radically change the relations of the members of the profession to each other and also to the public.

With increased knowledge of the natural history of diseases, together with the methods of prophylaxis and treatment, has developed the duty of the physician to instruct the man in the street upon these vital questions, within reasonable limits.

The medical practitioner cannot now decline to give to the public, through the lay press, professional views on the subject of infectious or otherwise communicable diseases, although formerly (and even now in some instances) it was considered unethical to do so. In the great field of preventive medicine a judicious discussion in the lay press of all subjects pertaining thereto is the only method whereby the co-operation of the public can be successfully enlisted. The only safety in such publicity, however, rests in the instruction of the people on matters which have been definitely settled in the school, in the laboratory, in the clinic. Until everything has been thus tested and proven, the man in the street can only be confused and hindered in his ambition for the protection of his health and life.

SUPPLEMENT TO THE MARCH JOURNAL.

...BULLETIN...

OF THE

School of Medicine

OF THE

University of Kansas.



THE CLINICAL DEPARTMENT AT ROSEDALE.

CONTENTS:

1. Appendicitis complicating pregnancy. *Associate Professor* ROBINSON
2. Operative intervention in eclampsia. *Professor* MOSHER.
3. Disease types in southern Kansas. *Lecturer* FURST.
4. Announcement as to entrance requirements.
5. Request for material.

APPENDICITIS DURING PREGNANCY.

ERNEST F. ROBINSON, A. B., M. D.,

Associate Professor of Surgery in the University of Kansas.

Kansas City.

Some months ago my attention was drawn to the subject of appendicitis during pregnancy by the following case:

April 17, 1906—Mrs. W., 23 years old, the mother of a healthy 3 year old boy, consulted me because of pain and persistent soreness in the region of the right ovary. [She stated that ten days previously she was walking along the street near her home, when she was suddenly attacked with severe pain in the region of pelvis and right ovary, and which was so severe, that she nearly fell to the street. She got home with great difficulty, however, and went immediately to bed. A physician was summoned, who applied an ichthyol vaginal pack and hot fomentations. This caused so great discomfort, that the pack was removed. The pain somewhat subsided, but the tenderness and soreness continued.

An examination ten days after the attack showed very rigid abdominal muscles, and a point of exquisite tenderness low down in the region of the right ovary. By vaginal examination a distinct mass was made out in the right ovarian region, and also the left ovary could be easily felt. It was about the size of a small orange, apparently cystic. There was great tenderness on examination, particularly the right side. The cervix was soft; the uterus enlarged; and the vaginal mucous membrane was dark in color. There had been no morning nausea, but the breasts were enlarged and tender.

A diagnosis of extra-uterine pregnancy was made with probably partial rupture of the gestation sack. Immediate operation was advised.

The following morning under ether anesthesia, Drs. Trexler and Knipe assisting, a median incision was made through the edge or the right rectus muscle. There was no extra-uterine pregnancy. The left ovary was enlarged, and contained a normal cyst of the corpus luteum of pregnancy. The right ovary was enlarged about the size of large walnut, and cystic. This was removed. The appendix was found pointing downward and inward over the brim of the pelvis. It was enlarged and club shaped, and adherent to the right ovary and to the intestines. It had not ruptured and was easily removed. The wound was closed without drainage. Primary union resulted. On the sixth day after operation, the patient aborted. The foetal tissue indicated a pregnancy of about three weeks duration.

This unexpected discovery of an appendicitis associated with pregnancy, brought the question to my mind, that possibly these conditions not infrequently complicate one another. On this point, however, the literature is unusually silent. Many writers on obstetrics and surgery mention appendicitis as a complication, but none, that I have been able to find, mentions its frequency. In order to determine this point in a relative way, I took occasion to write six of our prominent obstetricians and surgeons for their experience in this connection. The result was by no means uniform, or indicative of a definite conclusion. Out of 2000 cases of labor I was unable to find more than ten cases of undoubted appendicitis recorded; and of this number, only 2 were operated on during pregnancy; one at the fourth and one at the fifth month. Both were of the catarrhal type and both recovered.

The experience of the various practitioners consulted was remarkable in its variety. One reported two cases in 250 pregnancies; and another never had seen a case in almost 1000 labors. This great discrepancy comes from the fact that often an appendicitis is mistaken for a right tubal disease; nor is this diagnosis easy. How completely one condition may mask another is demonstrated by my own case herein reported. The character of the practice also may differ widely among individuals;—The general practitioner and obstetrician seeing unquestionably more cases of normal labor than the gynaecologist or surgeon.

In the past few years it was thought that appendicitis was much more common in men than women; but with the increase of our knowledge of the disease and our more accurate methods of diagnosis, statistics on this subject have been markedly changed. In the earlier editions of Deaver's work on appendicitis, he stated that 80% of all cases occurred in males; but in the last edition, he very materially modified this opinion. In 3000 cases operated on by himself, there were only about 60% males to nearly 40% females. Einhorn, (quoted by Dr. McRae,) in 18000 successive autopsies found perforating appendicitis in 55% of males and 57% of females. Robinson, (quoted by Deaver,) in 128 autopsies found evidence of past peritonitis, on or about the appendix in 68% women, and in 56% of men. Sounebery found 40% of his cases were in women. Hermes found in 1577 cases of appendicitis in Berlin, 40% were in females. The contention, that this per cent should even be greater in women, seems reasonable, as many cases of abdominal pain in the right iliac fossa are referred to the "tubes and ovaries" often without warrant. This opinion is also supported by the fact brought out by McRae, that in almost all cases in women, the attack of appendicitis occurred at or near the menstrual period. In 15 operations for appendicitis in women, he observed 4 cases, over 25%, in which there was also distinct disease of the right tube and ovary.

When we consider that over 61% (61.63% Deaver) of all cases of appendicitis occur between the 20th and 40th year, and that at least 40% occur in women, it seems reasonable to affirm that a large percentage must fall within the period of gestation, and prove a serious complication of pregnancy. More careful diagnosis in the future will, I am confident, demonstrate the truth of this contention.

The mortality of operations for appendicitis, during pregnancy, has been in the past remarkably high. Futh states that out of 42 cases, which he was able to find on record, 22 of the women died, a mortality of 52.3%. He ascribes the gravity of appendicitis during pregnancy "to the displacement of the caecum by enlarging the uterus, bringing the appendix close to the liver or uterus." This is, undoubtedly, a factor in rendering the resulting infection more severe and operative interference more difficult.

Abortion, also, is a most important factor in the mortality. It is particularly likely to occur in all cases of severe inflammation or abscess formation. In Futh's cases, it followed in all but one of the 37 operated upon. He says, "If the tendency to abortion in these cases can be controlled by opium or other measures, it may be possible to save more of the patients with appendicitis during pregnancy."

While these conditions unquestionably influence the mortality; yet, to my mind, the question of delay is the real and vital one that determines the death rate. Why should not a pregnant woman with appendicitis have the same chance of recovery, as her non-pregnant sister,—early operation? I cannot but believe that she should have, and will have, if her case of appendicitis is considered irrespective of her pregnancy. The chance of abortion, after an early operation, is very small indeed; for the operation is then done before any extensive inflammation has involved the uterus, or an abscess has rendered the patient septic. The operative manipulation is very slight in a "clean case" and abortion from the anaesthetic alone very rarely results.

The operative wound in the abdomen will not prove a complication; most certainly not in cases where drainage has not been necessary; and even in those cases that are for a time only partially closed, the danger is slight, when compared with the benefits of certain removal of a real menace to life.

In considering the literature on this subject, and also my own limited experience, I am absolutely convinced, that early operation should be undertaken in cases of appendicitis in the pregnant woman, just as it should be in the non-pregnant state. By so doing, the mortality will not be 50% or more, but will be nearer 5 to 10%, depending solely upon those factors that influence it in the general run of abdominal surgery.

OPERATIVE INTERVENTION IN ECLAMPSIA

GEORGE CLARK MOSHER, M. D.

Professor of Obstetrics, University of Kansas.
Kansas City.

Operative intervention in eclampsia resolves itself into a very nice calculation of the elements of risk involved. The absorption of toxins threatens the life of the patient, by their continued accumulation. The necessary shock to which *Accouchment force* exposes her incites to convulsion, due to irritation of the nervous system.

No other point in obstetric art is so very dependent on the practitioner's being able to weigh these contrasted dangers at their correct values.

Accouchment force, in the early days of surgical interference, meant a rough and brutal exhibition of the end justifying the means, and consequently, many deaths could be traced directly to the maternal traumatism of the operation itself.

Under modern methods of technique, this becomes less objectionable, and some of the leading teachers abroad and most of our own countrymen now endorse the surgical treatment as rational and conservative.

During the pre-eclamptic state, the symptoms which point to artificial interference are: rapid pulse, generally associated with high arterial tension; gastro-intestinal disturbances; lassitude; headache; decrease of all excretions, either rapidly or more slowly, the class of symptoms to be associated with intoxication through some infective absorption.

We always carry with us three classical prodromes of eclampsia; frontal headache—unilateral, visual disturbances, and epigastric pain.

When we consider that Green's Tables show a maternal mortality in ante-partum eclampsia of 46 and foetal of 69, in intra partum of 25 for each, in postpartum, maternal of 7 per cent, the suggestion is clear that the chances of the eclamptic subject are immeasurably improved, as soon as the uterus is empty.

If, in the face of all medicinal measures, the five eliminative processes are inadequate, so that the index of urea is steadily downward, and the amount of albumin steadily increasing, our duty is plain.

It is rather remarkable that the British school of obstetricians, and such German teachers as Winckel, and among the French, Charpentier, all oppose the emptying of the uterus in pre-eclamptic state, fearing that the irritation, resulting from the dilatation of the cervix, might precipitate the convulsion.

The opinions of such authority must be given their due weight, but American practitioners are usually in favor of the prompt emptying of the uterus. In the second stage of labor, there is practically unanimity, provided full dilatation is first secured. In the pregnant state, and in the first stage of labor, where the undilated cervix offers a complete barrier, the palliative method, when selected, will be followed by foetal death, the maternal mortality being 35 per cent.

As over 90 per cent of cases recover immediately after the uterus is empty, the delivery being accomplished early in the attack, it must be conceded, that the expectant plan, advised to avoid irritating the eclamptic uterus, should be condemned as being timid, irrational, and non-surgical.

When it has been decided that, in a given case, operative treatment is indicated, the choice can be defined as among the following:

1st, Caesarean section.

2nd, Mechanical dilatation of the cervix by any method.

3rd, Dührssen's multiple incisions, immediately breaking down the barrier of the cervix.

4th, Combination of mechanical dilatation and deep incisions.

Caesarean section in the hands of skilled operators, familiar with the method, and having every hospital facility, gives a maternal mortality of 36 per cent.,—a mortality due to shock, atony, hemorrhage, and auto-infection.

In these limited, select instances, the results compare favorably with the best treatment, not surgical. However, the average physician has neither careful training nor hospital to promise him the brilliant statistics of those who set the pace in making records. His case has the double danger of lack of equipment, and greater chance of infection, being conducted in the home without ideal surgical environment. Moreover, the atonic condition of the uterine muscle, making possible a fatal hemorrhage, and the irritation of the scar, uterine, as well as abdominal, and that associated with the peritoneal inflammation surrounding the sutures in the uterine wall, predispose to future eclamptic attacks.

The second method, that of mechanical dilatation and delivery, is the favorite in my hands. In two cases, which I have delivered lately, this was the method adopted, and the results were entirely satisfactory. Both patients remain apparently well at present.

The first came on in the sixth month in a patient who had suffered a pregnancy nephritis ten years ago, being delivered at term in eclampsia. In the present pregnancy, as soon as the urine showed a large percentage of albumin, being two grammes to the litre by the Esbach test, a daily urinalysis was made. At six and one-half months, a profuse hem-

orrhage occurred, the patient being blanched from loss of blood, the foetus still viable. Digital examination detected a boggy mass low down in the left side, from which, and the symptoms of bleeding, the diagnosis of left lateral placenta praevia was made. There was no dilatation, and with the hope of carrying the case to the 7th month, in interest of the child, the vagina was packed with gauze, left twenty-four hours and removed. Not a stain appeared, nor did it recur for ten days, when the albumin suddenly disappeared from the sample, foetal heart sounds not discernable, no foetal movement perceptible. Diagnosis of death of the foetus was made. Hemorrhage again set in. A rapid bimanual dilatation under deep anaesthesia was done. The rupture of membranes disclosed a prolapsed cord, pulseless. Version easily followed. The forceps to the after coming head completed the delivery. Shock was severe, and nausea with black bilious vomit kept up for twenty-four hours; urine scanty; albumin increased again for two days. The symptoms improved and the patient made an uneventful recovery.

In this case, the dilatation was somewhat difficult, owing to the unpreparedness of the cervix to give away, but with the anaesthesia in competent hands, complete relaxation gave every opportunity for rapid work which was completed in twenty minutes.

The second case was one which I had delivered after induction of labor, in consultation with the family physician two years ago. Her physician having, in the meantime, taken an official appointment, and being out of the city, she consulted me at his request,

Knowing what had been suffered in the former pregnancy, this was watched with great anxiety. No albumin, no casts, no oedema showed until ten days after term, but a fibroma, the size of a small orange, came to the front with the development of the uterine mass.

The delivery in this case also began with hemorrhage, due to the separation of the membranes from the lower uterine segment, the placenta being normally planted.

The cervix, undilatated, was also, in this case, made to disappear under anaesthesia, and the head engaging with uterine atony, the forceps were applied and a living child born.

In each case, the pulse of the pre-eclamptic state was 120 to 130, and continued for some three days following delivery, except when kept under by exhibition of *veratrum viride* in dose of 3 to 15 drops.

I mention these cases, being recent, and being at the present on the way to convalescence. In neither were casts found, although albumin was very marked, and the kidney insufficiency alarming, one case only eliminating 8 ounces in 42 hours.

As to the operation of Dührssen, that of the deep multiple incisions,

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I have never adopted this expedient but can readily see why it might become a choice of technique in cases demanding rapid extraction, where the interest of the mother and the child demand hasty interference.

The dilatation by Bossi dilators, and the deep incision to remove at once all barriers of the cervix should be the safeguard in such cases. Bossi dilators render the management of the dilatation stage mathematical and rapid. Judiciously used, they are perfectly safe.

The operative treatment in eclampsia where undue haste is used, the attempt being made to drag the foetus through an internal os not fully dilated, is the *bete-noir* of the inexperienced obstetrician. No doubt, many mothers perish from ruptured uterus, because in eclampsia, where the supra vaginal portion is found rigid until the beginning of the labor, the delivery is effected by sheer force rather than by art.

It is on account of the dangers of deep lacerations of the maternal soft structures, that one must wait for dilatation and disappearance of the cervix before attempting *accouchment force*; and during this time, experience proves to me, the great value of *veratrum viride* as a remedy that does things.

To conclude, intervention is always recommended in intra-partum eclampsia with dilated cervix, in late pregnancy, and in first stage of renal insufficiency with full bounding pulse, albumin 10 or 12 per cent. The choice of method should be rapid dilatation of cervix and then forceps or version to complete delivery. Very rarely the deep incisions of Duhrssen will be indicated.

Halbertsma's method of the ante-mortem Caesarean section is not endorsed by American teachers except in deformed pelvis or on a moribund mother, the foetal heart being perceptible.

Each case of eclampsia brings its own perils, and each must suggest the time and method of mechanical intervention.

DISEASE TYPES IN SOUTHERN KANSAS.*

O. J. FURST, M. D.,

Lecturer on Medical Economics in the University of Kansas.

That the climate of Kansas is conducive to long life, and that the majority of people live to a good old age, even to the allotted age of man, three score years and ten, is surely true, for in the Bulletin of the State Board of Health for April we have this statement:

"The simple temperate and rural life of the majority of the people of Kansas, together with the splendid climatic conditions which obtain during the greater part of the year, produce the ideal conditions which make for long life for her people. This fact is reflected in the vital statistics of 1905:

"Of the 9708 deaths whose ages are known, 4069 were over fifty years of age or 41.9%.

"The largest number of deaths occurring between any given periods of ages, was the period between sixty and seventy, which was 1298. Eight people reached the age of 100 and two over 110."

We are fortunate in not having any very large cities to breed and disperse disease germs, and to this we may credit in some degree, the number and effect of a great many diseases. It is also true that we have developed in Kansas, all or nearly all diseases common to the latitude. But that some of the diseases are modified in the number of cases, course and symptomatology, from other climates is also true.

That our climate is healthful can be seen in the report of Assistant Surgeons M. M. Shaner and F. H. Atkins of the U. S. Army made about 1874.

They say:

"It is of great salubrity and dryness. Snow flies rarely, and in small quantities, seldom lying more than a day or two. High winds are common, and frequently gales of alarming force often blow for many hours. During the warm months the direction of the wind is from south and east and this is reversed during the cold weather. Malarial diseases do not originate here; all cases having their origination elsewhere. No scurvy, pneumonia, pleuritis or phthisis, have occurred during 1872 and 1873, and but six cases of dysentery were treated in that time. Influenza has also been very rare.

Some will say that that report was made a long time ago, and but few people were then living in southern Kansas.

While that may be true as to the length of time we must remember that the southeastern part was quite thickly settled at that time. But grant the criticism; the report shows the non-existence of certain diseases in this climate until polluted by civilization and the change in the climate due to cultivation of the soil and forestry. If such conditions prevailed

*Abstract of a lecture before the senior class of the school of medicine.

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at that time it would surely be just to argue that our climate in and of itself, is beneficial to certain types of diseases, if not preventive or curative.

I know of no disease that is peculiar to this climate and not existing in other parts of our country or of any disease that is more severe or fatal here; but that the same diseases differ in symptomatology is true.

Our climate is changing in many respects;—especially is this true in regard to humidity, and consequently in the older and more cultivated sections and along streams we have pools of stagnant water which develop malaria to some extent. Dr. H. L. Snyder of Winfield, Kansas, informs me, that he demonstrated by microscopical blood examinations, 250 cases of malarial plasmodia in one year. Of course Winfield is near the south line of the state and many of these cases came from Oklahoma. Malaria on the account of change of climate is on the increase and even as far north in the state as where I live, Marion county, about 100 miles from the southern line, mosquitoes are on the increase and now are quite numerous where a few years ago they were seldom seen.

But even under these conditions malaria is the exception and not the rule; excepting a few of the counties along the Oklahoma border and here as said before a great many come from our new sister state.

Summer diseases of children such as entero-colitis, cholera infantum and others are prevalent in Kansas, with fatalities; but our statistics do not show as great a death rate as a great many other localities. In 18 years of practice in Kansas I have seen but two cases of cholera infantum, one acute case which died in about sixteen hours and the other a complication of ileo-colitis which also died. We do have quite a number of acute indigestions and diarrhoeas from errors in diet, but they respond readily to treatment. I am one who believes that we are advancing in the treatment of diseases and that there is efficiency in medicine and dietetics, but I do not believe that all the results we get in Kansas are due to these things. We have in Kansas a wind, air or atmosphere that is exhilarating and freshening and on account of this free circulation of air, even during our warmest months and hottest days there always is sometime during the twenty-four hours when we can get plenty of sleep. nature's health restorer. We can with impunity expose one of these children to this air even in a draft and in this way produce comfort, rest and sleep to our little patient and thus have the assistance of nature in our treatment.

Not long ago an educated gentleman who moved to Kansas from Indiana on account of the health of his little girl, spoke to me in regard to this. On one of the hottest days we had this summer, when passing my house he stopped and said, "Doctor, I left Marian sleeping peacefully,

on a cot in the draft between two windows with no perspiration or restlessness and she will awaken much rested. That is something we could not do in Indiana."

Again, while we have quite sudden changes in temperature they are not so great as in other states and we do not have that ill effect to deal with. For instance while practicing in Iowa I soon learned that after one of these sudden changes my little patients were always worse and I took the following precautions for overcoming it:

The family were instructed to put up a stove in the sick room and when these sudden changes come on build a fire in the stove and let the temperature drop slowly, and this nature does for us in Kansas.

Dr. Latta of Wichita says,

"Whatever it may be due to—enterocolitis in children is very severe in Southern Kansas and I dread the cases more, case for case, than I do typhoids. I am led to suspect that flies take a much more active part in infecting food and spreading this disease than they are credited with. Wherever there are no screens and swarms of flies around a house I regard these cases with much additional anxiety. With well ventilated and screened upstairs rooms I am sure I get the best results."

Dr. Graves of Dodge City says:

"As to the effect of climate on the diseases of the digestive tract of children I think it is decidedly favorable in southern Kansas. The free circulation of fresh air which is exhibited here to a much higher degree than in Illinois and other prairie states east, has a beneficial effect, the value of which can hardly be estimated.

I understand it has been claimed by someone that typhoid fever is different in this climate, from that of the eastern states and Europe or as delineated by authors of those localities.

My experience is that it is different in a great many states, but not so much so that it cannot be diagnosed readily by the description of the various authors. In an extended experience you will see all the variations, types and complications as pictured in text books. In this connection Dr. Latta says,

"I do not believe there is any essential difference in the type of typhoid fever found here and that of other localities, I have found no difficulty in harmonizing the cases I meet, with the cases described by authors working on the Atlantic border.

"I think I have seen all the typhoid characteristics here. And in my own practice or in the practice of those near me, all or nearly all the accidents and complications.

Many cases of typhoid here are mild, but others are as severe as anything I have seen described by authors. Fatalities I think are becoming less, but this is most likely due to improved modern treatment.

"This improved treatment is also responsible probably for the belief in the changing type of the disease. My own cases have averaged milder during the past fifteen years, than they did during the first eight years, but the treatment has been altogether different.

Dr. George Alexander Gibson of Edinburg, in his Practice of Medicine describes the invasions this way, "The period of incubation of typhoid

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fever is by no means settled. It has been stated at as long a period as three weeks and as short as one week." I would like to state here by way of parenthesis that in my own case, knowing when the infection took place, I was eight weeks in coming down. Dr. Latta might say that this was due to the improved mode of treatment, but as this occurred before the time of intestinal antiseptics and the prophylactic treatment was practically nothing it must be classed as a period of invasion. During this time I would have fever two or three days and then feel well for several days, but was able to attend to my studies in medical college all of that time. Gibson further says,

"During this time the patient may or may not feel ill. The invasion is less marked than in any other fever and it is a practical difficulty to ascertain accurately the exact day of the commencement. Moreover the patient may occasionally go about during a considerable time after the symptoms have set in.

"The onset may be marked by feelings of chilliness, with a discomfort and languor and a sense of feverishness more especially at night."

"The temperature is one of the most noteworthy and characteristic symptoms of this period. If an evening rise of 1 to 2° a fall of 1° or less the next morning succeeded by a further rise the next evening to a higher point than the preceding, along with a slight morning remission, so that the fever movement has a somewhat climbing or step like arrangement."

"By the end of the first week the evening temperature may have attained to the height of 102 or 103° or more.

In the second week the phenomena are intensified, temperature has arisen to 104° with slight morning remission.

Dr. Osler says,

"In the regular cases the fever rises gradually for the first 5 or 6 days." "Variation in the normal temperature curve are common. We do not always see the gradual step like ascent in the early stage; the cases do not come under our observation at this time."

"As a rule, the symptoms develop insidiously and the patient is unable to fix definitely the time at which he began to feel ill." "Chilliness occurs sometimes with the fever of onset."

In Kansas instead of the gradual rise of temperature as described by Gibson and Osler and modified by the latter in the variations and "chills occurring sometimes with fever of onset," the demon is often ushered in with a chill and you may have your highest temperature the first day or two, which gradually settles down to a regular typhoid course and never again through the course of the disease does the temperature reach the height of the first 24 to 48 hours.

In another type, the first week of observation the temperature may be normal mornings and lead you to think you have malaria to deal with.

We do have in south Kansas typho-malarial fever, that is a double infection as will appear later in the two case reports.

I discharged only a short time ago one of these peculiar cases in

which the highest temperature was on the third day and on every other day variation through the entire course of the disease.

Osler says—"There are cases described in which the chief features of the disease have been present without the existence of fever. They are extremely rare in this country. No instance of the kind has come under my observation. Fisk of Denver has met them."

From the information I have been able to obtain from several physicians this form of the disease is quite frequent in the southern part of the state. They are described to me as beginning suddenly, as before described, fever lasting 3 and 4 days; after that time all the other clinical symptoms of typhoid fever with great prostration extending over a period of 2 or 3 weeks.

I am indebted to Dr. H. L. Snyder of Winfield, for reporting the following:

"I received my education at Jefferson in Philadelphia, where typhoid or enteric fever as they are wont to name it, is endemic. My experience in practice has taught me that we have milder cases as a rule, some of which I wish to write of in detail.

"In three years of practice I have had ten or twelve cases of typhoid fever which I term *afebrile typhoid*.

"The first case of the kind was my brother, a young man then 21 years of age, having had the usual diseases of childhood, was sick with a chill and fever of 102°; blood examination showed certain malarial parasites. Temperature went to normal in two days, under quinine and tenderness in abdomen developed, with headache, coated tongue and nose bleed, bronchical cough, rose spots in their successive crops, appetite lost.

"Now the temperature, which is the point I wish to emphasize, never went above 100° F. The stools contained mucous sloughs and at times traces of blood. Convalescence slow with great weakness.

"Another case now under observation, taken sick July 5, 1906, headache, temperature 102° F. which subsided in two days under quinine. Abdominal tenderness, headache bronchial cough, rose spots in their successive crops, with a temperature ranging from 96° F. to 100 4-5° F. on one occasion only. The remainder of the time did not go over 99 4-5° F., stools offensive, sloughs, blood specks blood examination negative after first three days. Saw him last July 29, kept him in bed 10 days more on liquid diet, then allowed him to get up and increased food.

"Three days afterwards I was called again. Temperature 102, pulse 110, headache, pain in abdomen. Next morning temperature normal, next evening temperature rose suddenly from normal at 4 p. m., to 103° at six p. m. remained higher until toward morning then went to normal where it remained.

"Diet rigidly liquid. Three days later passed three ounces of blood by the bowels, with sloughs and mucus, pulse of 56 and poor quality. Now on the 25th day of relapse still passed mucous slough and specks of blood. Temperature 98½ to 98 4-5° F. pulse good from 58 to 84. In three years I have seen two severe cases of typhoid fever; one of which died and the other recovered."

The most insidious, deceitful, disastrous and dangerous disease I know anything about is *la grippe*. Dr. Latta says,

"*Lagrippe* is certainly much less fatal in Kansas than in the eastern states. It is probably as infectious here and as widely prevalent as anywhere in a country affording an

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equal population, but the fatalities are I think not nearly so great. Grip is however much more prevalent here than is recognized even among physicians. The term 'bad-cold' ought to be eliminated. Nine out of every ten of the so-called 'bad-colds' are infections of grip. Grip always demands care and caution no difference how mild. 'Bad-colds' are treated by both physicians and laymen as insignificant.

"No one would treat a recognized case of grip with the same indifference as they would treat a 'bad-cold' but most of the bad-colds are cases of grip, hence the possibilities of mischief."

Dr. Snyder says that they have had one epidemic in Winfield in two years and that of intestinal form. Following this, weakness was marked.

He says "Whether this epidemic was causative or not I cannot say, but think it was, of a number of cases of appendicitis." I believe that this may be true of the intestinal form, the inflammation of the mucous coat of the appendix not subsiding with that of the intestine. There is no organ or tissue of the body that does not suffer from its effects.

The deceitfulness of the disease consists of this: In our climate after two or three days of a more or less severe attack the patient seems to improve very rapidly and in another day or two, to all appearances and feelings of the patient and judgment of the attending physician, is well. This is the point. Let him exercise and sometimes ever so little as getting out on a chair or walking about his room and you have a relapse that is very dangerous affecting some special organ of the body and you cannot tell where until you have it.

In our part of the state the last two years the most serious complication has been endocarditis, with very sudden deaths others, extending into the chronic form with all the horrors of that disease. A few cases have recovered.

Asthma is not very prevalent in southern Kansas and I have known but one case come to the state that was not cured.

Bronchitis is not as prevalent as in lower and more humid climate. Dr. Latta says, "Some of my friends who have practiced further east (Indiana and Ohio) say that bronchitis is much less prevalent here than there," and that coincides with my experience in north Iowa. But since la grippe has been operating in Kansas we have had more bronchitis and pneumonia than before and the majority of cases a complication or result of grippe.

We also have years when an apparent epidemic of these diseases appears, but those are also the years we have the most la grippe.

Our pneumonia is most always of the bronchial type, especially in the beginning, a pleuro-pneumonia being the exception.

Dr. Dillon of Eureka says of pneumonia:

"Typical lobar pneumonia, in which the patient is seized almost without warning, with a violent chill, cough, sharp pains in the chest, rapid, short painful breathing,

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livid countenance, followed by high fever, bloody expectoration and complete hepatization, strictly confined to one or more pulmonary lobes and running such a definite course that you could confidently assure the sufferer, that his fever would be gone in about a week, that type of pneumonia is much more rare here than in the east and north. In my experience acute inflammation of the lungs here is much oftener a broncho-pneumonia less abrupt in its onset, hepatization less solid and complete over affected area, line of demarcation between the inflamed and sound tissue not so distinct, and duration of the disease much more variable and uncertain."

On account of our altitude and dry air the disease, heat or sun-stroke, so prevalent in the eastern states is practically unknown. This I again believe is due to the wind or free circulation of air.

Finally I want to give you a remarkable experience, not that I believe diphtheria is less prevalent or fatal here than other places. This experience is wonderful.

Dr. Latta says:

"A word about diphtheria and the rural districts. In certain neighborhoods, at least in Sumner county, diphtheria is practically unknown."

"In 22 years work in north Sumner I saw only one case of diphtheria. I was always watching for it, always dreading it, but it didn't come. Many times I thought I had it but the clinical symptoms and results disproved it. Bacteriological tests were applied only of late years and of course it is open to say I overlooked it, but the man who overlooks diphtheria generally finds it out by the accompanying disasters and these disasters did not occur. The one case I saw come from Illinois and brought the infection with him."

Peabody, Kansas.

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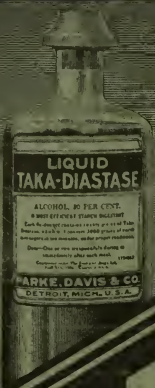
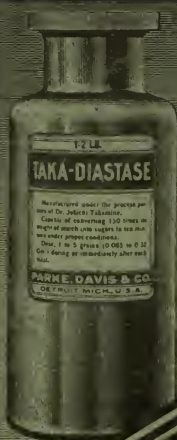
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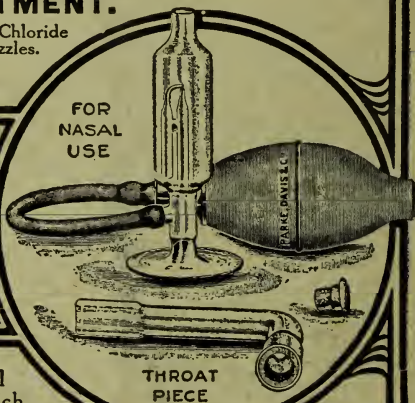
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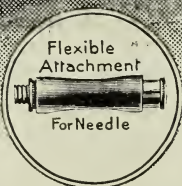
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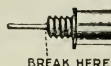
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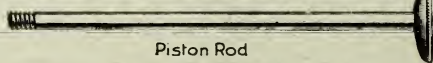


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